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ABSTRACT

This volume of 12 lessons--each written by either a medical or a mental health professional--provides expert information on a variety of medical and psychological issues in rehabilitative counseling. The lessons, each of which concludes with a few multiple-choice questions, are: (1) "Geriatric Alcoholism: Identification and Elder-Specific Treatment" (Jayne Reinhardt and George Fulop); (2) "Approaching Employers About the Americans with Disabilities Act" (Marilyn T. Oakes and Barry L. Oakes); (3) "Perspectives on Chronic Pain: Assessment and Treatment" (Dennis C. Turk); (4) "Aggression Replacement Training in Children and Adolescents" (Barry Glick); (5) "Chronic Fatigue Syndrome: Perspectives on Evaluation and Treatment" (Mark A. Demitrack); (6) "Counseling Dual Diagnosis Clients: Issues and Interventions" (Emil Chiauzzi); (7) "An Update on Computer Applications in Rehabilitation Counseling" (Donald A. Kates, Fong Chan, and Chow S. Lam); (8) "A Rational-Emotive Approach to Anger Management" (Windy Dryden and Jack Gordon); (9) "Alleviating Symptoms of Depression" (Mary Ellen Copeland); (10) "Placement Practices and Labor Markets for Clients with Disabilities" (David Vandergoot); (11) "Empowerment of Older Disabled Persons: A Rehabilitation Imperative" (Jane E. Myers); (12) "Work Hardening: A Dynamic Process" (Rock Weldon and Gary L. Sigmon). Contains an index. Each lesson contains references. (BF)

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Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 1

Geriatric Alcoholism: Identification and Elder-Specific Treatment

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EDITOR'S NOTE

Alcoholism is defined as the repetitive use of alcohol that causes physical, psychological, or social harm to the drinker and/or to others. The drinker typically denies the problem or refuses to deal effectively with it. 10%–15% of the elderly suffer from the disease.

Three distinct groups of elderly alcoholics are commonly described. The early-onset type begins to drink before age 40 and continues to drink into old age. A family history of alcoholism is common, and these clients suffer from other medical problems. Clients with late-onset alcoholism show no evidence of earlier drinking problems. For them, drinking is often a direct response to life stressors such as social isolation, limited family supports, physical and cognitive impairment, and financial limitations. Intermittent alcoholics demonstrate occasional episodes of heavy drinking earlier in life, alternating with periods of sobriety. Again, late life stressors are probably major contributors.

In this lesson, the authors review the general physical, psychological, and social impacts of drinking and point out some of the characteristics specific to older clients. The elderly are more sensitive to alcohol; they often have higher rates of concurrent physical and psychological disorders, including depression and suicide. Because they often receive prescription drugs, combining these with alcohol can induce detrimental side effects.

Alcoholism is commonly misdiagnosed or overlooked in the elderly, so all professionals should be especially alert to its possibility. The authors set forth principles of successful treatment approaches for elderly alcoholics; these not only encourage sobriety, but must also attend to such daily concerns as loneliness, loss of independence, and declining health. Behavioral therapy models have been effectively used. Outreach strategies are important as well. Unconditionally offered support and ways to renew hope and self-esteem are critical rehabilitation strategies.

Introduction

Although alcohol abuse and dependence decline with increasing age, they continue to pose a serious public health problem and a challenge to the treating rehabilitation specialist. Recognizing significant age-related characteristics of the elderly alcoholic can help identify elderly problem drinkers, implement elder-specific treatment plans, and help elderly alcoholics avoid the serious medical and social consequences of alcoholism. This lesson describes the number and types of elderly alcoholics and the diverse treatment programs available today.

Epidemiology of Elderly Alcoholism

It is estimated that **10%–15% of the elderly are alcoholics.**[1] As in younger alcoholic populations, **men outnumber women**. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates that approximately **10% of elderly men and 2% of elderly women are heavy or problem drinkers.**[2]

Problem drinking has been defined as the **"repetitive use of [the] beverage alcohol causing physical, psychological or social harm to the drinker or to others."**[3] Regier[4] cites a 0.9% overall one-month prevalence rate with 1.8% men and 0.3% women alcoholics among community-dwelling elderly. The DSM-III-R draws a distinction between "alcohol abuse" and "alcohol dependence."[5] **Despite knowledge that alcohol causes social, occupational, psychological, and medical problems, alcohol *abusers* continue to drink excessively. Alcohol-*dependent* people**, however, have **impaired control over their drinking behaviors**. The **dependence syndrome includes physiologic symptoms of tolerance and withdrawal.** The term alcoholic will be used in this report to describe those people who have problems with alcohol, abuse alcohol, or are alcohol dependent.

Clinical Settings

Researchers agree that active alcoholism in all age groups tends to be found more frequently in clinical settings rather than in community sites.[6] Brody[7] reports that among the elderly population, **10%–15% of all who seek medical attention for any reason have alcohol-related problems**. In their random sample of 84 patients from a general medical geriatric outpatient clinic, Fulop and Reinhardt[8] found that 4.8% of geriatric outpatients scored in the alcoholism range (>5) on the 25-question Michigan Alcohol Screening Test (MAST). After analyzing the results of a survey designed to determine the characteristics of elderly alcoholics, as well as physicians' practice patterns for alcoholism in all major patient-care departments at the Johns Hopkins Hospital, Curtis and colleagues[9] documented that **15%-26% of geriatric medical inpatients have alcohol-related problems**. In a report by the San Diego Association of Governments,[10] it is stated that **one fourth of seniors in psychiatric wards are alcoholic**.

Age of Onset

Three distinct groups of elderly alcoholics with different ages of onset have been described: early-onset, late-onset, and intermittent.[6,11-13]

EARLY-ONSET ELDERLY ALCOHOLISM:

The early-onset elderly problem drinker **began drinking before age 40** and, having survived the obstacles of alcohol abuse and dependence, continues drinking into old age. Some studies have indicated that these individuals are **more likely to demonstrate life-long addictive patterns and have weak affiliations with family, employment, or voluntary agencies**.[13] Demographic characteristics show that **family**

alcoholism was more common among early-onset drinkers than among people who began drinking after the age of 60.[14]

In reviewing the records of 216 elderly alcoholics who were admitted to the Alcoholism and Drug Dependence Unit (ADDU) at the Mayo Clinic between 1972 and 1983, Morse[15] also found that the **early-onset drinkers exhibited more medical problems than the other two groups of elderly alcoholics** (late-onset and intermittent). They also found that early-onset alcoholics reported having a greater number of diagnoses which included **cirrhosis of the liver, peripheral neuropathy, and cerebellum degeneration**.

LATE-ONSET ELDERLY ALCOHOLISM:

Late-onset elderly problem drinkers begin abusing alcohol in later life, exhibiting no evidence of previous drinking problems. These excessive drinkers are more likely to have enjoyed **high occupational status** throughout most of their adult lives,[13] and report **fewer family histories of alcoholism**.[16] Atkinson[6] found that **late-onset problem drinkers exhibited greater psychological stability and higher socioeconomic status** than did early-onset drinkers.

The etiology of late-onset alcoholism remains controversial. Many researchers[16-20] hypothesize that **late-onset elderly alcoholism is a direct response to life stressors**. These stressors include some of the social problems that are often present for all older people such as **social isolation, limited family supports, and physical and cognitive impairment**—as well as **financial limitations** that may put restrictions on their activities.[21]

Finney and Moos[20] defined life stress as a **"component of one or more of several combinations of factors that may trigger or perpetuate drinking problems."** They critically examined several studies that empirically associated life stressors with the late-onset of problem drinking in the elderly as well as with the triggering of problem drinking in the elderly intermittent group. They concluded that much of the evidence acquired from these studies is consistent with the stress theory. However, because **"the pervasiveness of the stress hypothesis in the alcoholism and gerontology fields derives more from its intuitive appeal than from empirical research,"** they believe that **stress can only be considered one component** among a combination of factors attributing to the late-onset of excessive drinking in older people.

Finlayson and colleagues[19] reviewed the medical records of the 216 elderly patients who had been treated for alcoholism between 1972 and 1983 at the Alcoholism and Drug Dependence Unit (ADDU) of the Mayo Clinic. They found that **various life events were associated with or exacerbated the early and late onset of problem drinking** among 211 ADDU elderly patients. Stressors were attributed to the onset of their exacerbated drinking in 81% of the late-onset drinkers.

INTERMITTENT ELDERLY ALCOHOLICS:

A third group, **intermittent alcoholics**, is also present. These individuals have experienced **occasional episodes of heavy or problem drinking earlier in their lives which alternated with periods of sobriety.** Similar to the case of late-onset elderly alcoholism, **relapse among the intermittent elderly problem drinker may also be considered a response to the stressors of growing older and losing various motivating factors for remaining sober** (i.e., job, spouse, good health).[11,12,18]

Effects of Problem Drinking on the Elderly

In all age groups, the effects of alcohol can be quite severe. Alcohol **slows brain activity** and **impairs mental alertness and judgment**. Additionally, alcohol use **alters physical coordination and reaction time**, which increases the risks of falling and having accidents. Over time, excessive drinking can cause **permanent brain and central nervous system (CNS) damage, as well as impair the liver, heart, kidneys, and stomach.**[22]

Although problems associated with occupational functioning and interacting with friends and neighbors, as well as those related to the police, appear less often for elderly individuals, Hinrichsen[23] reports that **negative physiological and societal implications are still quite pertinent; even limited use of alcohol among elderly persons may cause more significant problems than among individuals under the age of 60.**

Alcoholism also creates other costs, not only to the alcoholic and significant others, but to innocent bystanders, such as car accident victims. Two million alcohol-related car crashes occur each year at a total cost of 10–15 billion dollars.[24]

Elderly alcoholic patients present special problems that are not seen in younger populations. **Older people's reaction to alcohol is much stronger than in their younger counterparts.** Since lean body mass decreases by about 10% from age 20 to age 70 and the body water component accounts for a smaller percentage of total mass, the **amount of alcohol consumed is distributed to a smaller volume, resulting in a higher blood alcohol concentration.**[18] Therefore, **using quantity and frequency as criteria to diagnose elderly problem drinkers could be very difficult and quite**

inaccurate. Additionally, **the rates of concurrent medical disorders, death, depression, and suicide are higher among geriatric problem drinkers** than among nondrinkers of the same age group.

PHYSIOLOGIC COMPLICATIONS:

Hurt and co-investigators[16] found that **alcoholics had a higher frequency of psoriasis and peptic ulcer disease than did the general elderly population**. Morse[13] also reported that organic brain syndromes were the most "important psychiatric problems" of the alcoholic group.

Additionally, compared with their younger counterparts, elderly alcoholics are **more prone to liver disease, cancers and other chronic illnesses, and organ damage**.[25] Excessive drinking can also **double many common age-related physical ailments**, such as occult cardiovascular disease, osteoporosis, hypoglycemia, hyperuricemia, and hypertriglyceridemia.[6]

Studying alcohol use among a group of semi-independently living nonagenarian (>90 years old) men and a group of 65–75-year-old men of similar demographic characteristics, Jensen and Bellecci[26] found significant evidence that suggested **alcohol use was related to the frequency of major medical illnesses among both groups**. They reported that the **heavier drinkers tended to have higher frequencies of major illnesses** when compared with those who reported rarely or never drinking (3.8 vs. 2.4). Additionally, after studying 200 patients with liver disease, Potter and James[27] reported that **28%** of alcohol liver disease in persons 60 years or older was found to be related to alcoholism, with mortality rates of **34%** and **53%** at 1- and 3-year follow-ups. In comparing laboratory test results of the elderly ADDU patients admitted during 1972-1983 with those of a group of younger ADDU (mean age 44.3 years)

patients admitted during 1978-1979, Hurt and colleagues[16] found that out of 10 laboratory tests reviewed, results from five of these tests were more often abnormal in the elderly alcoholic group.

MEDICATIONS AND ALCOHOL INTERACTIONS:

Although the elderly constitute about 10%–12% of the American population, they take more than 30% of all prescription drugs and 40% of all over-the-counter (OCT) medications. According to the FDA, **50% of all drugs consumed by older adults can interact with alcohol.**[28] Because older adults experience increased sensitivity to all drugs that are central nervous system depressants, **combining alcohol (a CNS depressant) with any one of these drugs can be fatal to the older adult.**[28] In addition, using alcohol with such commonly prescribed drugs as CNS depressants, analgesics, cardiovascular, antidiabetics, and anticoagulants can significantly alter motor and sensory functions, and negatively affect vitamin absorption.[29] Additionally, Atkinson[6] found that **80% of elderly OTC drug users simultaneously ingest alcohol, prescribed medications, or a combination of the two.**

PSYCHOLOGICAL COMPLICATIONS: DEPRESSION AND SUICIDE:

In a group of 61 elderly patients treated for alcoholism, Pottenger and colleagues[30] found that **59% were clinically depressed.** Bienenfeld[31] reports that **depression is uniformly present in alcoholics, especially since alcohol has a direct depressant effect**; also, **society tends to isolate drinkers, leading them into a spiral of loneliness.** Dupree and co-workers[32] reported that a large percentage of the clients participating in a 24-day alcoholism pilot treatment program drank alone at home and mostly reported being depressed or lonely just prior to taking their first daily drink.

Alcohol had been considered in 35% of all suicide cases.[33] Osgood[34] reports that excessive alcohol use and depression have been associated positively with elderly suicide rates. Compared with other age groups, the elderly population has the **highest rate of completed suicides**. Overall, this group accounts for 17%–25% of all suicides.[35]

Identification of Elderly Alcoholism

POOR DETECTION:

In a report by West and colleagues,[33] Dr. David H. Solomon notes that defining alcoholism in the elderly population is quite difficult because **criteria that are normally used to detect alcoholism in other age groups (such as driving violations or accidents, public disruptions, or absences from work) may not be applicable to the elderly**. There is also a **low index of suspicion**, and lifestyle difficulties that can result from excessive alcohol use in younger populations are often absent in the elderly, resulting in **less problems with the police and the legal system**. Additionally, Bienenfeld[31] points out that many elderly alcoholics are widowed, generally retired, and often do not drive. Therefore, they **seldom attract attention** because of trouble with work or marriage; this lowers the reported prevalence rates of elderly alcoholics, because many of these cases remain undetected.

In a study examining the physician's ability to diagnose alcoholism among a group of elderly patients, Curtis and colleagues[9] found that whereas the physicians caring for each patient identified 60% of their young screen-positive patients with alcoholism, they only identified 37% of the screen-positive elderly patients. They also report that **patients who were white, female, or had completed high school were less likely to be diagnosed by these physicians. Intervention strategies were recommended in 50% of the nonelderly diagnosed as alcoholic, but only 24% of the elderly were considered for treatment.**

PROBLEMS OF DENIAL:

The denial of the alcoholic and significant others only adds to the major problems of underdiagnosis of, and lack of proper treatment for, elderly alcoholic patients. Bienenfeld[31] notes that the **most difficult aspect of detecting and treating alcoholism in patients of any age is overcoming the denial that is commonly associated with this disease**. He explains that **family members, close acquaintances, or even public agency and state institution personnel often act as enablers for the elderly alcoholic by providing a refuge for this individual**.

Additionally, **an employer may wish to carry along an older, dysfunctional employee as a token of appreciation for past service. Guilt feelings may also prevent the spouse of an elderly alcoholic from confronting his/her mate about the problem.**[31]

SCREENING INSTRUMENTS:

The rehabilitation professional can increase the detection of alcohol problems by asking a few pertinent questions or administering a brief screening questionnaire. One concise screening instrument is the **four-question CAGE**. The questionnaire asks participants about:

- their feelings about the need to **Cut down** on their drinking;
- whether they have been **Annoyed by other people's criticism** of their drinking;
- their bad or **Guilty feelings** about their drinking; and
- if they have ever had an **Eye opener** (a drink first thing in the morning) to "steady their nerves."[36]

Another screening instrument, the **Brief MAST (Michigan Alcohol Screening**

Test), is a 10-item version of the more detailed 25-question original MAST and seems also to be well tolerated by the elderly.

Treatment and Prevention Strategies

Once identified, the **elderly alcoholic responds well to treatment.**[37,38] Treatment options for the elderly **similar to those for young alcoholics** (e.g., **psychotherapy, detoxification and rehabilitation, disulfiram [Antabuse], Alcoholics Anonymous,** etc.) will not be discussed here because of general awareness of these options. However, a number of **age-specific model programs** have been identified. In general, **treatment may be in mixed-age or elder-specific groups**. Some have argued that treatment intervention for elderly alcoholics can be most effective when delivered through facilities that specifically treat elderly clients rather than through general psychiatric or medical institutions. These may include senior citizen centers, outpatient geriatric medical or psychiatric facilities, nursing homes, or geriatric home care programs.[38]

Although some programs have been developed specifically to meet the demands of the elderly alcoholic,[32,39-41] the need for these programs continues to outweigh the number of those developed and implemented.

Model Geriatric Alcohol Treatment Programs and Strategies

Olsen-Noll and Bosworth[18] explain that treatment for the elderly problem drinker must **focus on such daily concerns as loneliness, loss of independence, and declining health**. Zimberg[38] suggested that the treatment approach for elderly alcoholics should place **emphasis on compensating for various age-related losses**

and stresses that are not applicable to younger populations.

Several strategies have been delineated in the treatment of geriatric alcoholism. These modalities include, but are not limited to, **inpatient and outpatient settings**, including those which are elder-specific, nonelder-specific, or mixed-aged, as well as those implementing the disease, behavioral, and self-management models of treatment, outreach strategies, peer support, and family involvement.

Inpatient Mixed-Age Treatment

DISEASE MODEL:

Some inpatient programs incorporate the **disease model of alcoholism** into their treatment strategies. Hurt and colleagues[16] conducted a retrospective epidemiologic study of the 216 elderly patients of the Mayo Clinic's ADDU. Their goal was to determine, among other things, the demographics of a group of elderly alcoholics, and to analyze differences between early- and late-onset alcoholics. The ADDU was already in place when the researchers retrospectively examined the medical records of the 216 participants (the ADDU itself is not an age-specific treatment center since it treats both older [age greater than 60] and younger patients).

The ADDU's treatment approach is based on the **disease concept of addiction**. The treatment program integrates "multidisciplinary-staffed modalities for treatment of addictions with psychiatric and specialty-oriented medical care." Upon admittance to the 28-day program (28 days in the first 2 years of the study, but those who entered in or after Year 2 stayed only 21 days), each patient underwent an initial diagnostic assessment, which included a medical and psychological examination.[16]

Intervention strategies include **education through films and lectures,**[19] **individual and group psychotherapy, addiction counseling, physical exercise, family participation, an introduction to Alcoholics Anonymous,**[16] and **aftercare planning.**[19]

Although the researchers primarily focused on the participants' medical and social information, they **assessed the elderly alcoholic's quality of life** through demographic data, medical characteristics, laboratory test results, treatment outcomes, and comparisons of early- and late-onset alcoholism.[16] They found that the **frequency of serious medical disorders for this group was higher than would be expected for the overall population of the same age.** They concluded that **more intensive treatment might be required for some elderly alcoholics because of the high frequency of major medical and psychiatric problems among this population.**[16]

Other investigators such as Zimberg[38] and Thomas-Knight[42] have expressed the view that **therapy directed at the social, psychological, and physical stresses associated with aging would be quite sufficient for treating elderly alcoholics.** However, Hurt and colleagues[16] refute the notion of simply socializing elderly alcoholics and claim that **this group must receive comprehensive treatment comparable to, if not exceeding, treatment provided for younger alcoholics.**

BEHAVIORAL MODEL:

An inpatient alcoholism treatment program was instituted at the Veterans Administration Center in Jackson, Mississippi.[43] After examining the results of a survey of hospital admissions from the medical and psychiatric wards at the Center, researchers found that **40%** of entering patients demonstrated a significant alcohol problem. To combat this situation, Miller and colleagues[43] explain that emphasis was placed on **changing the individual's daily life functions—attitudes, skills, and behaviors.**

Within this framework, alcoholism is viewed as a **socially acquired habitual behavior pattern that enables the alcoholic to avoid or escape from unpleasant or anxiety-producing situations, gain attention from friends and family, and avoid withdrawal symptoms associated with the termination of drinking.**[43]

One strategy of this threefold treatment approach is to change the problem drinker's attitude by decreasing the immediate reinforcing properties of alcohol through **electrical, chemical, or verbal aversion therapy techniques.**[43] Having identified several of the behavioral and nonbehavioral factors associated with persistent drinking, it is possible to develop a **behavioral inventory** by **identifying the behaviors that are incompatible with excessive drinking and ultimately to teach the alcoholic new skills to cope with life.**[43]

Another component of this approach encourages the elderly alcoholic to participate in a **token-economy system, which offers rewards through privileges**. The intent of this reward system is ultimately to **reinforce positive, therapeutically goal-oriented behaviors which are incompatible with excessive drinking.**[43] Miller and colleagues[43] explain that **the Mississippi Program offers social and vocational counseling based on the notion that the individual will remain only temporarily sober unless this person enters directly into a satisfying and health-promoting employment and social environment**. However, **because many elderly alcoholics are retired, it would be necessary to provide counseling that would address the specific needs of this target population**.

Similar to other alcohol treatment programs, the Veteran's Administration Mississippi program includes **family treatment** with a goal of producing change that will lead to growth among family members, as well as promote **healthy marital relationships** for married patients.[43]

OUTREACH STRATEGIES:

The Senior Alcoholism Services (SAS) of Vancouver, Washington is an example of another age-specific residential alcohol treatment program that implements a different approach to treating the elderly alcoholic. Created as a result of a needs assessment of the elderly population in Clark County, Washington,[39] the project's primary goal is to help older alcoholics stop drinking and begin living through sobriety by **turning their problems into new opportunities**.

As previously mentioned, Bienenfeld[31] explains that **denial** is a primary characteristic of alcoholism. **Outreach alcoholism counselors must break through this denial**. In the SAS program, the counselors' major involvement with the clients has been in the **motivational and the aftercare treatment phases**. Rather than waiting for patients to arrive at the SAS office voluntarily, counselors make themselves available to hospital patients and nursing home clients who have been identified as having alcohol-related problems. Additionally, counselors visit potential clients' homes to encourage them to participate in the program.[39]

Clients who have been motivated to participate in the program are generally **admitted for 21 to 30 days of intensive treatment which includes individual counseling, family and couples counseling, self-esteem building programs, and other activities that can serve as alternatives to excessive drinking.**[37] Additionally, by assisting the SAS patients in filling out public assistance forms for housing and health care, social workers demonstrate that the clients' needs will be met regardless of the financial costs.[37]

PEER SUPPORT:

Dunlop and colleagues[39] also found that, in the SAS Project, **sensitive peer**

support groups consisting of other elderly recovering alcoholics serve as reinforcing factors to recovery. Additionally, they reported that **geriatric problem drinkers respond just as positively to group counseling as do younger populations if the specific concerns of the elderly are addressed**, including estrangement from children, loss of driving ability, and death of a spouse.

FAMILY INVOLVEMENT:

In his experience treating patients in a geriatric psychiatric program and consulting in medical home care programs and nursing homes, Zimberg[44] reports that along with group therapy, socialization, and medical care, **family casework is a preferred strategy in treating alcoholism among elderly patients**. Family involvement is a large component of the SAS program. Many family members enabled their elderly alcoholic relatives to continue drinking excessively because they felt that they were protecting them by allowing them to "enjoy one of the final pleasures." Families are encouraged to attend meetings to acquire alcoholism information and continued emotional support.[37]

Elder-Specific Outpatient Treatment

For other elderly alcoholic individuals, **outpatient treatment programs** offer the most beneficial treatment. At the time of entry into a special outpatient alcohol treatment program, 36 active elderly alcoholics were assessed on selected demographic, psychological, and alcohol-related variables. In comparing the treatment outcomes of 14 early-onset problem drinkers with 22 late-onset problem drinkers from this group, Atkinson and colleagues[14] found that **both of these elderly groups are much more compliant to treatment than are younger alcoholics**.

BEHAVIORAL AND SELF-MANAGEMENT STRATEGIES:

Similar to the in-patient alcoholism treatment program at the Veterans Administration Center in Jackson, Mississippi,[43] the Gerontology Alcohol Project (GAP) described by Dupree and colleagues[32] applied **behavioral and self-management strategies designed specifically for elderly alcoholics**. An elder-specific, 24-day pilot day treatment alcoholism program located in Florida, the GAP was developed to investigate the location, description, and treatment of **late-onset alcoholics**. **Potential participants were asked to assess five life areas** in which the quality could be affected by excessive drinking. Additionally, the quantity and frequency of alcohol consumption among the late-onset drinkers were determined.

The investigators divided the project into **four treatment modules**. These modules were designed for participants to identify the components of the general and ultimately their own behavior chains which led to their drinking problems. In addition to the analysis of drinking behavior, **participants were taught self-management techniques for high-risk situations, alcohol information and education, and general problem-solving skills.**

The researchers found that success, as defined by participants maintaining their respective goals of alcohol consumption, was quite high among those who completed the treatment program. They found that after a 12-month follow-up period, **most of the participants in their program demonstrated significant improvements in functioning** as well as an **increase in the size of their social networks**.

Dropouts of the project had lower estimates of success and higher depression scores, and also tended to drink more alcohol than the graduates. The investiga-

tors also found that **the great number of late-onset drinkers warrants age-specific treatment programs.**[33]

As a component of the comprehensive Alcohol and Drug Dependence Treatment Section (ADDTS) of the Psychiatric Service at the Portland, Oregon Veteran's Administration (VA) Medical Center, **the ADDTS Class of '45 program** offers patients **evaluation, detoxification, and residential and outpatient services that employ paraprofessionals, recovering addicts, and professional staff members.** This elder-specific program is available to any veteran accepted for outpatient alcoholism treatment who was on active military duty during or before 1945.[45]

The Class of '45 program offers **three concurrent groups of 30 participants.** Groups meet weekly for 1 1/2 hours, specifically during daytime hours, to increase public transportation accessibility for all older participants who don't drive and prefer not to travel at night. Many patients also attend a local elder-specific Alcoholics Anonymous meeting for additional support.[6]

COMPARISON OF MIXED-AGE AND ELDER-SPECIFIC GROUPS:

In their Class of '45 study, Kofoed and colleagues[41] retrospectively examined the course of outpatient alcoholism treatment by **comparing** the results of 24 elderly alcoholics who were **mainstreamed into a typical mixed-age outpatient group** with the results of 25 elderly alcoholics treated in the **special geriatric peer group** program.

In comparing the elderly-specific Class of '45 group to the mixed-age groups at the ADDTS, Kofoed and colleagues[41] found that the most obvious difference between these two groups was the **quick development of a strong attachment among group members in the elderly peer group.** Participants showed a ready acceptance of all

group members, leaders, and group goals. Group members also exhibited a sense of camaraderie with each other.[45] The researchers found that overall, **members of the elderly peer group were more compliant, remained in treatment significantly longer, and were more likely to complete their treatment programs than were elderly participants of the mixed-aged group**; the process became fragmented in the mixed-age groups as older clients increased in the group-oriented program. **Many older clients in the mixed-age group also reported feeling uncomfortable when outnumbered by younger clients.**[41]

The researchers noted that the major difference between elderly problem drinkers and their younger counterparts stems from the older drinkers' **attitude and responsiveness to treatment strategies**. After comparing the elderly peer group with the mixed-aged group, Kofoed and colleagues[41] concluded that elderly alcoholics respond to socio-therapeutic intervention and **prefer peer groups** to age-heterogeneous groups.

Therapeutic Community

In the therapeutic community, **client-staff groups are established to discuss clients' problems**. Members of this community are offered greater **autonomy to make decisions about their own needs**. Atkinson[6] noted that therapeutic community intervention has been found to be effective in reducing problem drinking and other behavior disorders in both the community and institutional settings.

Zimberg[44] reports that in their study of 103 elderly alcoholics in treatment, Rosin and Glatt found that the **most beneficial services provided for this group were those that included interaction with other people,** such as environmental manipulation, medical services, day hospital care, and home visits by staff or good neighbors.

Therefore, **a schedule that includes volunteer or part-time jobs coupled with structured, interactive nonworking time would serve as a practical substitute to a work situation** for recovering elderly alcoholics.

Factors in Elderly Treatment Responsiveness

After studying over 600 subjects for almost 40 years, George Vaillant[46] identified factors associated with recovery from alcoholism. Two factors that were strongly operative in the Class of '45 project[45] were the **increased sources of unconditionally offered support** and a **source of renewed hope and self-esteem.**[46] Other factors include a **dependence on a nonchemical substitute for alcohol,** which is a strong component of the SAS recovery group in Vancouver, as well as the **use of external, ritual reminders** that even one drink can lead to pain and relapse.

Felker[47] explains that the community-based **Elderly Recovery Group** in Wisconsin incorporates all four factors of recovery. The group offers a **nonchemical substitute for alcohol** through the **continual concern and active problem solving** efforts offered by each member and the group's professionals. Through group readings and discussions of each other's infrequent setbacks and relapses, **members receive external, ritual reminders of the dangers** involved in taking even one drink. Additionally, the program offers **increased sources of unconditional social support and a source of renewed hope and self-esteem.**[47] Similar to the Class of '45 program,[6,45] the Elderly Recovery Group offers **nonjudgmental social support** to renew members' faith, hope, and self-esteem.[47]

The Elderly Recovery Group was developed in response to the need for an alcohol

and substance abuse/dependence support group among the 350 older people housed in three Wisconsin senior citizens' complexes. After conducting a community assessment of this population, two health professionals who had been working with this community realized the high prevalence of alcoholism, which was often accompanied by abuse of prescription medications within this residential elderly population.[47]

Having decided to develop the group, they succeeded in acquiring the appropriate staff through a joint effort between various health care agencies and well-developed alcohol treatment programs.[47] Although many residents of the senior citizens' complexes in Wisconsin had repeatedly been to the County Alcohol Detoxification Unit, Felker[47] notes that **many problem drinkers didn't perceive the seriousness of their conditions or believe that their health was actually in danger**.

Six months prior to initiating the group, the trial stage was implemented in the form of a **one-on-one interaction between the professional staff and apartment residents**. This trial period was quite instrumental in the decision-making stage, because the trust that developed between the apartment residents and the health professionals encouraged these geriatric alcoholics to agree to participate in the developing groups. Having made the decision to join the program, the residents ultimately adopted the group concept.[47]

Felker stated that since group sessions were held in community rooms within the apartment complexes, many members felt stigmatized by their non-drinking neighbors. In response to this, **the group incorporated role-playing strategies to develop methods of responding to neighbors' remarks**. He noted that as members practiced the skill of assertiveness, they became better able to handle the stresses associated with the confrontations with their neighbors.

Although the group had very few rules, it did have some norms, or common beliefs, about the way members were expected to behave. Since trust is a major determinant of a group's success,[48] **strict respect for members' confidentiality** outside of the meeting was stressed.[47]

CONTINUED CARE SUPPORT GROUP:

Similar to the Elderly Recovery Group in Wisconsin, the **Helping Hands Program** at the Alcoholism Treatment and Education Center (ATEC) in Long Beach, California, is a continuing care support group, free of charge and open to any elderly alcoholic. Most group members are referred from the inpatient Alcoholism Treatment program at Memorial Hospital Medical Center.[40]

The clearly defined goals of the Helping Hands group include helping older, recovering alcoholics develop a **positive, creative sobriety**; establishing and maintaining a **continuing life support system**; and **developing and expanding the channels between the Helping Hands program and the community senior services agencies, alcohol rehabilitation facilities, and other community resources.**[40]

The Helping Hands program is comprised of two phases. **Phase I addresses the physical withdrawal of alcohol**. Members are sent to a **3-week inpatient detoxification program** at Memorial Hospital's ATEC unit. Family and close friends or neighbors are encouraged to become involved in the alcoholic's treatment program early in this person's recovery process. Emphasis is placed on the **development of self-responsibility and autonomy,** which is the premise of a follow-up support system.[40]

During Phase II, the social/psychological evaluation period of the Helping Hands program, the patient's environment is assessed with the main focus being

the patient's hospital discharge. The evaluating counselor looks for **strengths, interests, and other significant factors that can be restored** and directed to contribute to that patient's recovery.[40]

Several **group participants volunteer to reach out to newcomers by telephoning them, offering peer counseling, and following up on their progress**. Other members have established additional Alcoholics Anonymous (AA) and Helping Hands groups in communities which needed these support tools.[40]

A special **daily therapy group for the older discharged alcoholics** also addresses age-related issues as well as problem drinking.[40] Upon leaving the ATEC inpatient program, a discharge plan resource network refers patients to AA meetings and other support systems. Glassock noted that some elderly problem drinkers use the Helping Hands group as a stepping stone for entry into other programs like AA.

Conclusion

Alcoholism remains a complex problem faced by all age groups. The elderly alcoholic is particularly subject to underdetection and undertreatment, despite the notable success rate of multiple treatment modalities. In fact, the elderly may have even better treatment responses than their younger counterparts, especially if treated in peer groups, and when social and medical factors contributing to alcoholism are addressed. With the "graying" of America, the rehabilitation specialist will need to become increasingly familiar with the special treatment needs of the elderly alcoholic.

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Questions Based on this Lesson

1. Which of the following is *not* a characteristic of early-onset alcoholics?
   A. Life-long addictive patterns with weak family affiliations
   B. Greater psychological stability than late-onset alcoholics
   C. Lower occupational and socioeconomic status than late-onset alcoholics
   D. Family alcoholism is more common than in families of late-onset alcoholics

2. Which of the following statements about older populations and alcoholism is *true*?
   A. Since the prevalence of alcoholism in elders is well-documented, health care and rehabilitation professionals are often quick to diagnose alcoholism.
   B. Older alcoholics often come to treatment reluctantly, usually only at the insistence of family members.
   C. Late-onset alcoholics have a significantly high level of problems with the police and employers.
   D. In addition to being at an increased risk for physical disorders, elderly alcoholics report an extremely high rate of depression.

3. Which of the following does *not* characterize the behavioral model of treatment for alcoholism?
   A. The focus on alcoholism as a disease
   B. Emphasis on changing the individual's daily life functions
   C. A token-economy system of rewards through privileges
   D. Electrical, chemical, or verbal aversion therapy

4. Which of the following evidence does *not* support age-specific treatment for elderly alcoholics?
   A. Older participants in the mixed-age Class of '45 group reported feeling uncomfortable when outnumbered by younger participants.
   B. Older drinkers have different needs and generally respond to different treatment strategies than do younger drinkers.
   C. Overall, members of the elderly same-age peer group remained in treatment longer and were more likely to complete their treatment programs than were elderly participants in the mixed-aged group.
   D. None of the above

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 2

Approaching Employers About the Americans with Disabilities Act

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EDITOR'S NOTE

The main purpose of the Americans with Disabilities Act (ADA) is, in its own words, "to provide a clear and comprehensive mandate for the elimination of discrimination against individuals with disabilities." Indeed, the ADA has provided significant opportunities for rehabilitation professionals to advocate for their disabled clients, and has paved the way for substantial benefits to those individuals. However, one obstacle that has taken many rehabilitationists by surprise is the degree of resistance to the Act exhibited by employers. Even counselors who had built up excellent rapport with certain employers have suddenly found themselves in an adversarial relationship with these same employers when attempting to implement ADA requirements.

The authors of this lesson maintain that much employer resistance derives from ignorance about the specific provisions of the Act. For example, employers often believe that ADA compliance will be prohibitively expensive, that only major corporations will be affected, that the Act will justify increasing government intrusion into business life, and that the Act will be underenforced.

The most important key to diffusing an employer's hostility, the authors believe, is the rehabilitation professional's attitude. Rather than becoming a "watchdog," it is important to present oneself as a consultant who will help the employer understand the provisions of the ADA and realize how the ADA can, in fact, benefit everyone involved.

The authors provide several proactive strategies for converting a potentially adversarial relationship into a positive one from the outset. Offering free ADA screenings can "open the door;" counselors can also reduce resistance by having thorough knowledge of ADA provisions, helping employers establish priorities, and developing a cost-effective work plan for compliance.

Introduction

The Americans with Disabilities Act of 1990 (ADA) has created many new opportunities for rehabilitation counselors to make a positive impact on the business community. Requests for facilities accessibility help, job task analysis, and assistance with reasonable accommodations are becoming commonplace. **"Speaking the language" is important.** Rehabilitation counselors who are perceived as "spendthrift bleeding hearts" or who take a combative "NIGYYSOB" (Now I've Got You, You SOB)[1] stance do much to damage both the profession and the interests of our disabled clients. **It is possible and quite appropriate to take a pragmatic approach**. After all, the best client advocacy makes friends, not enemies.

The average business owner is interested in two questions:

- **Will the ADA cost or save money?**
- **Will the ADA create or solve problems?**

There are several ways to demonstrate to employers how **implementation of the ADA is in their enlightened self-interest. Practical, cost-effective solutions**, as well as a **focus on employers' rights to a drug-free workplace and improved workplace safety**, can do much to improve employer attitudes toward the ADA. The purpose of this lesson is to provide the professional rehabilitation counselor with a pragmatic basis on which to approach employers concerning the ADA.

Getting Started

Before approaching employers, **it is critical for the professional rehabilitation counselor to be very knowledgeable about the ADA**. One estimate is that it takes at least 1000 hours of study and reflection before an ADA consultant is ready to enter

the business community.[2] Our experience is compatible with this estimate. It is not possible to "fake it till you make it" with ADA, and doors will slam shut if you try.

Even if the rehabilitation counselor has read and understands ADA Title III, **ADA must also be reconciled with local building codes and relevant federal codes** such as those put forth by the Occupational Safety and Health Administration (OSHA), Mining Safety and Health Administration (MSHA), Environmental Protection Agency (EPA), Federal Aviation Association (FAA), Department of Transportation, and so forth. It is important to remember that, in general, **the standard affording the most protection to the disabled person pre-empts other standards**. For example, if a machine modification is needed as an ADA reasonable accommodation but it violates OSHA standards, OSHA would pre-empt ADA because of OSHA's stricter health and safety code. Similarly, if a state disability rights standard is more strict than ADA, the state standard pre-empts ADA. There are unlimited possibilities to create ADA accommodations that violate other relevant standards.

Finding a technical professional to help with the professional knowledge base is important. Potential sources include industrial, structural, and/or safety engineers; renovation architects; and compliance officers at the relevant state or federal agency (OSHA, MSHA, EPA, FAA, Department of Transportation, and/or boards of building codes). Rehabilitation engineers with structural engineering backgrounds can also be helpful.

Our bias favors using **industrial engineers, because this field has the broadest technical knowledge base** of those named above. Industrial engineers have been modifying machines, equipment, and buildings for many years, all the while meeting

production requirements as well as state and federal guidelines governing health, safety, and building codes. Like rehabilitation counselors, they are accustomed to doing anything with nothing: modifying a machine, a piece of equipment, or a building to meet the needs of a disabled person is not too great a challenge for them.

As a word of caution, **some technical people, as well as some rehabilitation providers, have appropriated ADA as a money-making scheme. Be very careful that any technical consultant is completely independent and does not have a sales contract for water coolers, elevators, automatic door openers, chair lifts, or other related products**. We view this as a conflict of interest that may affect the quality of the information provided by the technician.

Fees for technicians range from $65 to $125 per hour, and fee agreements should be worked out well in advance. The more data gathering the rehabilitation counselor does for the technical consultant, the less it will cost. In certain instances, ADA technical assistance can be provided by telephone or by mail.

Opening the Door

Because of the proliferation of "overnight experts" with few skills and fewer ethics, **the climate in the business community at present is skeptical and rather unreceptive toward all ADA practitioners**. Many employers take a "wait and see—if they don't make me, I'm not going to do it" approach. Others take the approach, "no one knows what any of this means, and so I won't act until the courts rule." It often takes as many counseling skills to get in the front door in the first place as it does to effect a reasonable accommodation for a disabled worker once the door is open.

The **strategies that we have found most effective have been those that are factual, based on problem-solving techniques, and that take the long-range view.** The door can be kicked open, but that takes years of litigation and generates much ill will. We have focused on strategies that encourage the employer to open the door from the inside.

FREE ADA SCREENING:

One very effective tool to get the door open is to **offer a free screening for ADA compliance**. The rehabilitation counselor offers to look at the employer's physical plant and hiring practices, then makes recommendations for compliance, at no cost. It takes no more than an hour, not counting driving time. There can be no catches—**it must be absolutely free**, though we charge a modest travel fee for out-of-town assignments. **The professional counselor's knowledge of the statute and implementation must be thorough**. If mistakes are made at this point, there likely will never be a chance for remediation.

Having a tool such as free screening cannot be effective unless employers know that it is available to them. Obtaining free advertising to attract employers to use such a service is fairly easy: the business sections of most newspapers carry announcements of this type. Chambers of commerce and other civic groups often announce services of this nature to their members. Trade associations are another good source of free advertising. **Newspaper writers are always looking for an authoritative quote, and networking with them is an excellent way to increase exposure**.

Inexpensive advertising includes bulk mail and small advertisements placed in trade and business journals. Hosting continental breakfast meetings and speaking at other

public forums are also good ways to attract attention to the ADA. For the truly motivated, hosting seminars and workshops is a lot of work, but gives tremendous exposure to ADA services. Quite literally, anything rehabilitation counselors can do to keep their names in the newspapers as sources of help for ADA is effective in attracting employers to the free screening.

In the free consultation, we fully review both their physical facility and their job descriptions. Many employers have no job descriptions and others have only a list of jobs. Very few actually have a written description.

In reviewing the physical facility, we look at parking lots, sidewalks, ramps, main entrances, accessible pathways to the job applications area, floor covering, restrooms, writing surfaces, job applications, telephones, water coolers, building safety standards, elevators, and fire exits. These are the minimum items for an employer to be considered ADA-accessible prior to renovation. An ADA technical consultant should be able to train any rehabilitation counselor how to do a basic ADA facilities walk-through.

When writing job descriptions, we favor a modified form of the U.S. Department of Labor (DOL) system of job task analysis. Any of the available treatises will do—the 1972 *Handbook for Analyzing Jobs* (currently out of print), the 1982 *Guide to Job Analysis*, and/or the 1991 *Handbook for Analyzing Jobs*. Our practice is to use the format from the 1972 *Handbook* with the information from the 1982 and 1991 books, and we have detailed the process in our *Job Task Analysis Tutorial*. We developed the JTA format for our industrial clients, with specific input from EEOC, and it is based on DOL information. We have devised some time-saving short cuts; until the courts rule otherwise, we are satisfied that the process we recommend—though simple enough that any human resources professional can master it quickly—will meet EEOC requirements.

We have several reasons for favoring **the DOL method**. In addition to being the **only existing federal standard for job task analysis,** it has some **50 years of research** behind it, and it is a **clear, straightforward approach** that is easily understandable to applicants, employers, and enforcement officials. The General/Specific Aptitude Test Battery is undoubtedly the most heavily litigated employment test ever devised, but has consistently passed muster with the courts. The DOL system isn't perfect, but it is far ahead of anything else available and we believe that it is the most likely to meet ADA requirements, especially if litigation occurs.

During the free screening, **we make verbal recommendations to the employer and we solve whatever specific problems we can on the spot**. We often leave a sample job description, as well as a statistical breakdown of the disabling conditions and syndromes recognized by our state governor's Committee on Employment of Persons with Disabilities. Even though employers are not bound by this list, it serves to **open their eyes to the broad spectrum of disabilities.** Many employers still define "disability" as "wheelchair" and are most surprised to learn otherwise.

If employers have problems that require us to refer to the rules and regulations to answer their questions, **we also include brief research of no more than 15 to 20 minutes in the free screening**. If they want extensive research, a written report, assistance in preparing a compliance plan, liaison services with EEOC or DOJ, prepared written job descriptions, or any other services, we give them an estimate and go on the clock at that point. **We also inquire about their workers' compensation and safety situation.** If we can make quick recommendations in these regards, we do so, and we always leave material about our services.

Before we conclude the visit, we tell the employer that many consultants claiming expertise don't actually have it and warn them about the spurious "certified ADA consultants." We also provide them with **questions to ask those who approach them about ADA services**. These questions include:

- **How long have you been in business?**
- **How long have you been working on ADA?**
- **Are you licensed in any field?**
- **How much experience do you have providing job placement services to the disabled?**
- **Are you bonded and insured?**

The vast majority of our ADA walk-throughs do not result in any immediate additional work, which was our expectation. Our position is that **most employers can take care of 90% of ADA themselves with proper guidance**. However, we **make it clear to the employer that we want to be considered first when they need a paid consultant** to do the remaining 10%. Employers are generally suspicious of "something for nothing," so assuring them that rehabilitation counselors want something from them over the long term makes the free screening beneficial to all parties.

Employers are much more likely to cooperate if they perceive that the rehabilitation counselor understands their frame of reference. Not charging them for things they can do themselves communicates understanding with their position and needs. Employers who have been charged for inappropriate services are wary of any ADA service provider, even a good one. **The free screening is reassurance that we are interested in a long-term relationship with the company**.

The free screening may also allow rehabilitation counselors to suggest jobs in which the employer might effectively place persons with specific kinds of dis-

abilities. Most employers welcome such information. One of our client companies is a small coal mining operation. Convinced that no disabled person could ever work in their establishment because of the physical demands, they were most surprised to learn that they have three jobs that can be done by persons with mobility impairments, including one that could be done from a wheelchair. They were equally surprised to learn the broad scope of disabling conditions that could be considered protected under ADA. A brief glance around the premises revealed several persons with disabilities already employed, whom the employer did not view as being disabled because they could do all duties of their respective jobs! **We pointed out that ability to do the job is the whole message of ADA.**

At the walk-though, we also **ask for referrals for other businesses that might benefit from a free ADA screening, which results in additional networking.** An unintended (but welcome!) side benefit of this kind of networking is that we have **more friendly doors available for our disabled job placement clients.**

Reducing Resistance

Offering the free screening allows the employer to open the door to you from the inside. However, before they let you set foot inside, most have questions, and the quality of your answers determines whether they will let you in. Here are some of the most common ones, along with our answers:

1. What's the catch?

Answer: There is no catch. The free screening is really free and includes a walk-through of the facility, review of the hiring practices, and verbal recommendations. We believe that employers can solve 90% of the problems of ADA by themselves with

a little direction from us. We want to be considered first when an outside consultant is needed to help with the remaining 10%.

2. How can you afford to do this?

Answer: Most rehabilitation organizations require a marketing specialist. We prefer to spend the money educating employers instead of paying a sales representative. This isn't free to us, but we have diverted our marketing budget to pay for free screenings. (Please note that nonprofit operations can apply for grant funding to cover free screening expenses.)

3. ADA doesn't cover me, does it? Does my building have to be accessible?
(Believe it or not, we still get asked these questions.)

Answer: ADA affects most businesses, and for most businesses, January 26, 1992, is the compliance date. There are a few small-business exceptions, but most businesses are covered right now. If a business is not in compliance, its best bet is to formulate a compliance plan, get prices and establish projected timetables, and contact EEOC to review the plan.

4. You want me to turn my company in to EEOC?

Answer: In general, **it is far better for the business to seek EEOC's attention than to wait for a complaint to be filed**. If a plan of compliance has been reviewed and approved by EEOC, it serves as an informal shield. However, **once the plan of compliance has been approved, only great calamity should interfere with its implementation**. EEOC is unlikely to be amused by chicanery.

5. ADA doesn't *require* job descriptions, does it?

Answer: Quite right. However, there are a **number of powerful reasons to have job descriptions in order**. First, they **allow you to match the right workers to the right jobs and to improve all worker selections**, separate and apart from disability. Second, it is **practically impossible to institute a reasonable accommodation if you don't know what the job entails**. Third, in the event of a dispute, **job descriptions prepared after the fact will have little value as evidence**.[3] Fourth, if you have job descriptions for the first time when doing the hiring, the human resources representative will know exactly what a front line widget maker does. Fifth, **if the DOL system is used, the employer will be able to use the local office of the state Job Service to screen workers using the G/SATB**. Aptitudes for appropriate jobs can be measured and a more scientific approach to job matching can be obtained. Sixth, **job descriptions serve as an exacting basis on which job-related physical examinations can be devised**.

The argument against having thorough job descriptions is that it gives the employer more latitude in the event of a dispute. This is a weak argument that reduces the dispute to what attorneys call a "swearing match." **The more objective evidence the employer has, the better**; hence the need for job descriptions.

6. I can't afford to do everything at once. Where do I start? What do I do first?

Answer: **The first priority is to decide what are the common-use areas of the building**, and these areas should be accessible to the public. Examples of common-use areas include: public parking lot, accessible pathways to the building, main access doors, lobbies, elevators, human resources and/or job applications areas, building areas where the public may need access (cafeterias, restrooms, meeting spaces, offices, etc.), public

telephones, and any similar areas. **Next, decide which areas of employee use need to be accessible.** Examples include breakrooms, accessible pathways to the building, employee parking lots and entrances, offices, office furnishings and equipment, non-public restrooms and cafeterias, and any similar areas. Once these two areas have been defined, the primary immediate need is two-fold:

- **Public access and accessibility**
- **Accessibility for existing employees**

For public accessibility, the first priority should be parking and building accessibility: ramps, sidewalks, curb cuts, public access door, etc. **For employee accessibility, the first priority should be accessibility of immediate work space, relevant doorways, and accessible pathways within the building, followed by employee restrooms and breakrooms.** In case of necessity, the disabled worker could always use the public accessible parking spaces, restrooms, cafeterias, and entrances.

The **second priority for public accessibility** should be **internal building accessibility**: floor covering, inside doorways, internal accessible pathways, public restrooms, elevators, water fountains, etc. **The second priority for employee accessibility should be employee parking, accessible pathways, and non-public entrances.**

After the areas have been defined and priorities established, **make a written plan of action for implementation, including dates of starting and completion and prices for all tasks, and file the written plan with EEOC.** Along with this, **employers should provide minimum access immediately.** If this means a sign saying, "Blow your horn if you need assistance," so be it. In extreme cases where moving or

bulldozing the building down would be cheaper than renovating, both the employer and the rehabilitation counselor must be creative.

7. Nobody knows what to do now, do they?

Answer: That is a common misconception, and one that comes primarily from lawyers not understanding rehabilitation. ADA is overwhelming if it is approached only as a legal document, and the approximately 400 cases litigated in 17 years under the Rehabilitation Act of 1973 provide little guidance because of the difference in the burden of proof. Based on everything we have seen and heard, **EEOC strongly desires problem resolution in the field instead of complaints and litigation**.

Rehabilitation counselors and industrial engineers have been practicing ADA constructs for over 50 years and can help with problem resolution. **ADA is an attempt to legally codify the body of professional practice for these two groups of professionals and apply it to the business community at large**. There is much professional experience within rehabilitation counseling and industrial engineering that can help employers implement ADA quickly, easily, and with little consternation. Approached in this manner, ADA assumes normal proportions and is quite manageable.

First: **Employers should attain minimal accessibility**, as outlined in an earlier section of this lesson.

Second: **Any remaining accessibility problems and timetables for solving them should be filed with the local EEOC office as a good faith gesture.**

Third: Employers should always remember that **the simple approach to reason-**

able accommodation consists of only three items, as follows:

- what the disabled person requests
- what the employer elects to offer
- what the court orders

Disputes that reach the court for resolution will be the expensive ones; disputes that are resolved between a person and the employer are generally cheaper and more favorable to all parties. Rehabilitation counselors, with technical support, can help resolve disputes equitably.

Fourth: Ignoring disabled persons is probably the most expensive solution of all. It is a mistake to assume that disabled individuals are any less litigious than the population at large. Rehabilitation counselors have the capability to help employers solve problems in a cost-effective, pragmatic fashion to keep disputes out of court. This concept should be emphasized when dealing with employers.

Fifth: Getting job descriptions in order should be a high priority for the employer, because of the lack of good defenses under ADA. "Inability to perform the essential job functions" and "good faith effort" are about the only good employer defenses to an ADA claim.

Unless an activity is a direct violation of OSHA, "direct threat" isn't likely to succeed in ADA litigation. There is always a lawyer out there who can find a doctor somewhere who will swear that his/her sentiments are the most current medical thought on the subject, regardless what the employer's expert says. "Dueling docs" is similar to swearing matches, and the employer would be perceived by the jury as picking on the disabled person.

"Undue hardship" is even less likely to succeed, and would require the company to open the books to the jury, which makes them a matter of public record. Opening the books could include revealing customer lists, special discounts, trade secrets, chemical formulae, and exclusive manufacturing procedures. **Most business owners don't want their competitors, suppliers, customers, and ex-spouses knowing their true financial condition**, so we don't think "undue hardship" is a useful defense to pursue. All that leaves is "essential functions" and "good faith."

Sixth: **Unless employers have been through a disability discrimination claim, they have no idea what they are getting into.** They will hear from the mayor, the chamber of commerce, the local media, the Ladies' Aid Society, the altar society, and various other groups previously unknown to them—and nothing said will be kind. They will endure heaping scorn and unending bad publicity until the dispute is resolved, because they will be perceived as picking on a disabled person. That is, even if an employer wins a case, the company loses. **Obviously, it is cheaper and more favorable to stay out of court and out of the public eye.**

Seventh: Although at this time we have found no published statistics to support these findings, **the labor lawyers we talk to around the country view disability discrimination cases as those with the most "jury appeal."** The perception of a big, rich employer taking unfair advantage of a disabled person creates a very sympathetic plaintiff in the eyes of the jury, regardless of the reality. **The attorneys who have litigated state discrimination statute cases have no taste to enter the federal arena.** We strongly advise employers to stay out of such a situation; this most often means negotiation and compromise.

Workers' Compensation and Workplace Safety

Workers' compensation is a national crisis, if you believe what you read.[4] In truth, the crisis was more likely caused by bad real estate investments[5] and possibly insurance company fraud[6] than by injured workers, but **the move is afoot nationwide to reform workers' compensation. The workers' compensation crisis and reform movement around the country gives rehabilitation counselors a unique opportunity to educate employers about ADA.**

Many state workers' compensation laws do not take the ADA into account and contain provisions that are illegal under ADA. An example is the "fraud in application" provision in the 1992 Alabama workers' compensation reform. This section provides that if an applicant falsifies medical information on the employment application and subsequently sustains a work injury because of failing to disclose medical history, it may be grounds for dismissal and may also negate workers' compensation benefits.[7] According to the September, 1992, update by the National Conference of State Legislatures, 10 states currently have similar provisions governing fraud and fraud in application.[8] **However, under the ADA, asking medical questions during the applications phase is forbidden, and ADA would pre-empt the state workers' compensation law.**

The confusion of state workers' compensation law versus ADA provides another opportunity to befriend employers and open doors for disabled injured workers. Rehabilitation counselors who become expert in resolving conflicts between ADA and state workers' compensation are usually received gratefully by employers.

A second area of concern is **workplace safety and accident prevention**. At the time of this writing, 21 states have health and safety provisions written into their workers' compensation statutes.[8] However, all states are subject to OSHA and the Drug-Free Workplace Act. Both of these federal statutes can be used to design a healthier, more accident-proof environment.

Employers have many rights to safety programs under ADA. A good safety program eliminates many workers' compensation problems and also keeps the employer clear of OSHA. If people aren't getting hurt in the first place, there is little need for doctors, lawyers, insurance claims representatives, OSHA investigations, and rehabilitation counselors. **ADA allows employers to appropriately match workers to jobs, which is likely to increase workplace safety, decrease accidents, improve productivity, and decrease employee turnover**. All things considered, ADA is good business.

ADA is too new to have many statistics about increased workers' compensation savings. However, an experiment by Community Hospitals of Central California (CHCC) produced encouraging results. In 1991, CHCC set up an aggressive return-to-work program fashioned after ADA guidelines. Managers are encouraged to modify work and to use injured workers for temporary assignments whenever possible. The financial results have been remarkable: in 1990, the average workers' compensation claim cost $1,030; in 1992, the average is $285. Overall expenditures for workers' compensation hit $2.7 million in 1990, but are expected to amount to $1 million in 1992.[9] **The savings on workers' compensation easily paid for the ADA implementation, and did so in less than 2 years**. We strongly believe this is not an isolated example of the effectiveness of ADA to control workers' compensation costs.

Caveats

Rehabilitation counselors are responsible for all information provided and should update their professional liability insurance accordingly. It is unwise to assume that the employer will take full liability if the counselor guesses incorrectly.

As much as we try to persuade employers that proper implementation of ADA is in their enlightened self-interest, some employers don't respond. For this reason, we follow the *Wall Street Journal* reporting of significant legal cases around the country, as well as human resources and ADA-watch publications. Our recommendations are listed in the suggestions for additional reading. We have spoken with several employers who are quite positive ADA doesn't hold implications for them. We plan to re-contact them after a suit has been filed against an employer in their industry.

Summary

The most effective ways to approach employers about the ADA is to develop practical, cost-effective solutions to the problems posed by ADA and to show employers how ADA can benefit them. A free ADA screening is an effective tool to open doors for dialogue with employers. Rehabilitation counselors should **focus on employers' rights under ADA to a safe and drug-free work environment**, and **demonstrate to them how safety and accident prevention can save money, increase productivity, and decrease workplace problems**. Rehabilitation counselors who speak the language of employers and are perceived as "friend" can do much to further the interests of their disabled clients.

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Questions Based on this Lesson

5. The authors believe that consulting with a technician is important because:
   A. Only trained technicians have thorough knowledge of local building codes.
   B. Boards of building codes mandate that only a licensed technician implement accommodations for ADA.
   C. Technicians and industrial engineers have been modifying machines, equipment, and buildings for many years and are likely to be acquainted with the legal production requirements.
   D. They usually have sales contracts with manufacturers of related products.

6. Which of the following statements about employer resistence is *not* true?
   A. Many employers take a "wait and see—if they don't make me, I'm not going to do it" approach.
   B. The best way to overcome resistance and induce ADA compliance is to "kick the door open" by threatening to report the company to the EEOC.
   C. The appropriate role for the rehabilitation professional to assume is that of a consultant and an information source.
   D. Employers are much more likely to cooperate if they perceive that the rehabilitation counselor understands their frame of reference

7. Components of a free ADA screening include all of the following *except*:
   A. The requirement that the employer guarantee you any and all consulting services required in the future.
   B. A review of the physical facility.
   C. Verbal recommendations to the employer for on-the-spot solutions.
   D. Suggesting jobs in which the employer might effectively place persons with specific kinds of disabilities.

8. Which of the following is ***not*** a reason for the employer to have a coherent system of job descriptions?
   A. They are required.
   B. They allow the employer to match the right workers to the right jobs and to improve all worker selections.
   C. In the event of a dispute, job descriptions prepared after the fact will have little legal value.
   D. It is difficult to institute a reasonable accommodation if you don't know exactly what the job entails.

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 3

Perspectives on Chronic Pain: Assessment and Treatment

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Editor's Note

As Dr. Turk notes in this lesson, a significant proportion of Americans suffer from chronic pain. Chronic pain is a major challenge for both counselor and client. It represents a therapeutic situation replete with numerous dilemmas, some of which are rooted in the realm of the client's unconscious. For example, chronic pain sufferers who adopt the attitude that they are disabled will tend to avoid physical activity altogether; this leads to greater physical deconditioning, which often is supported (and thus reinforced) by a spouse who may fear further injury; in the end, such clients increase the likelihood of amplifying and distorting pain symptoms, thereby reinforcing the counterproductive and psychologically damaging perception of being more disabled than is the case. Although this psychological process does not *cause* physical pain, it can exacerbate a pain episode. Therefore, the rehabilitation professional must maintain a balance between focusing on ways to alleviate physical pain, and warding off the client's deepening sense of frustration and demoralization as the search for relief continues.

Dr. Turk thoroughly examines the concept of pain and outlines various therapeutic interventions available to the rehabilitationist in counseling chronic pain clients. Numerous conceptualization models can help the therapist arrive at an understanding of the nature of pain. Perhaps the most comprehensive model is the Cognitive-Behavioral Transactional Perspective, which, unlike other models of more narrow scope, considers interactions of environmental influences, physical factors, and pain perceptions and responses *over time*. This distinction is key, because throughout therapy, clients constantly learn behavior that shapes their perception of their pain and introduces emotionally charged personal experience into the therapeutic process. Thus, we can see the importance of psychological evaluations in the rehabilitation of chronic pain clients.

Psychological evaluations can also help the counselor choose the appropriate therapeutic intervention(s) and define realistic goals of therapy for a given situation. Because environmental factors differ across cases, no one persistent pain sufferer is the same as another. Interventions include Operant Conditioning, Cognitive Reconstruction, Problem Solving, Self-Management Strategies, Coping Skills Training—all of which Dr. Turk examines at length.

Regardless of the adhered-to conceptualization and the chosen therapeutic method(s), one must remember that chronic pain is neither solely physical nor solely psychological. And, although chronic pain's obstacles are great, they are not insurmountable—especially if the burden of the chronic pain is shared equally by the counselor, the client, his or her employer, family, and friends.

Introduction

The quest to control pain has existed since the beginning of recorded history. Mention of pain treatment has been found in Egyptian papyri dating back to 4000 BC. Yet, despite the lengthy history; advances in knowledge of sensory physiology, anatomy, and biochemistry; and the development of analgesic medications and other innovative medical and surgical interventions, pain relief remains elusive for many people.

By definition, chronic pain extends over long periods of time and persists in spite of the best efforts of health care providers. **The average duration of pain noted for clients treated in specialized pain clinics exceeds 7 years; reports of pain for 20-30 years are not uncommon among such patients.**

For persistent pain sufferers, the ongoing search for relief usually is met with failure and a deep sense of frustration and demoralization. They confront not only the stress of pain but also a cascade of ongoing stressors (e.g., financial, family) that compromise all aspects of functioning. Moreover, the experience of "medical limbo" (that is, the presence of a painful condition that eludes diagnosis and that carries the implication of either psychiatric causation or malingering on the one hand—or an undiagnosed life-threatening disease on the other) is itself the source of significant stress and can initiate psychological distress or aggravate a premorbid psychiatric condition.

Health care providers share feelings of frustration as clients continue to report pain, sometimes in the absence of identifiable pathology. Family members, friends, co-workers, and employers also feel the burden of the problem. On a societal level, pain creates a major burden in lost productivity and disability benefits in addition to health care expenditures. Third-party payers are confronted with escalating costs when persons remain disabled despite extensive treatments. Indeed, pain management continues to be an extremely challenging problem for the sufferer, health care providers, and society. In sum, chronic pain is a demoralizing situation that compromises all aspects of the life of the sufferer and his or her family.

The Concept of Pain

Systematic efforts to treat pain have been closely aligned with how pain is conceptualized and evaluated. As described in the following section, **models have been used to conceptualize pain in an effort to understand and improve the current state of pain treatment.**

SENSORY-PHYSIOLOGIC CONCEPTUALIZATION:

The traditional biomedical view of pain dates back several hundred years and is based on a simple linear view that assumes a **close correspondence between a biological state and symptom perception.** In this sensory-physiologic view, **the extent of pain severity is presumed to be directly proportionate to the amount of tissue damage.**

Some therapeutic interventions for clients with persistent pain derive from the sensory-physiologic models. For example, surgical procedures have been developed to ablate the pain pathways from the periphery to the central nervous system, and analgesic agents have been synthesized to block these pathways. Advanced diagnostic imaging and laboratory procedures have been developed to evaluate the nature and course of tissue damage in an effort to explain the patient's reports of pain and thereby suggest the appropriate therapeutic intervention. However, several perplexing features of persistent pain complaints are not consistent with the traditional sensory-physiologic model (Table 1).

Table 1
CHALLENGES TO THE SENSORY-PHYSIOLOGIC MODEL

- Clients with objectively determined, equivalent degrees and types of tissue pathology vary widely in their reports of pain severity.
- Asymptomatic individuals often reveal objective radiographic evidence of structural abnormalities.
- Clients with minimal objective physical pathology often complain of intense pain.
- Surgical procedures designed to inhibit symptoms by severing neurological pathways believed to be subserving the reported pain may fail to alleviate pain.
- Clients with objectively equivalent degrees of tissue pathology and treated with identical interventions respond in widely disparate ways.
- There appear to be only modest correlations among physical impairment, physical functioning, pain report, disability, and response to rehabilitation.

PSYCHOGENIC CONCEPTUALIZATION:

As is frequently the case in medicine, when physical explanations prove inadequate to explain symptoms, psychological alternatives are entertained. **If organic findings are absent or the client's pain complaints are "disproportionate" to objectively determined physical pathology or if the complaint is recalcitrant to "appropriate" therapy, then it is assumed that psychological factors must be involved. In such cases, the client's pain is often categorized as "functional" or "psychogenic"—not "real," and the basis for the client's pain report is assumed to be emotionally determined.** Thus, the psychogenic model of persistent pain suggests pain reports in the absence of objective medical data can be explained by personality characteristics of the client or the presence of a psychiatric disorder.

The organic-psychogenic distinction **makes several unwarranted assumptions.** First, it assumes that **adequate means exist for reliably measuring the amount of "pain" experienced** and that **normative data are available for various pain syndromes to determine whether an individual's report is "excessive."** However, as noted, it is recognized by many clinicians that **people with very similar medical findings show extremely diverse pain responses to nociception** (a sensory process that conveys information about tissue damage).

Additionally, the organic-psychogenic dichotomy assumes current medical and diagnostic procedures can identify all pathologic sources of pain. However, **the predictive power of medical examinations and diagnostic tests** (their sensitivity and specificity) **are quite low for clients with persistent pain.**[1] For example, **physical examination, laboratory tests, and imaging procedures can be expected to lead to a definitive diagnosis in only about 20% of those with chronic low back pain.**[2] Conversely, a significant number of asymptomatic persons will show evidence of significant physical pathology on diagnostic procedures such as magnetic resonance imaging (MRI)[3] and myelograms.[4]

The somatogenic-psychogenic dichotomy further **assumes that no individual differences** (e.g., in sensory sensitivity) **other than psychopathological ones influence pain perceptions.** Finally, the organic-psychogenic dichotomy **assumes that a psychiatric problem and a pain disorder cannot co-occur in the same person or that emotional problems cannot result from a chronic physical disorder.**

MOTIVATIONAL CONCEPTUALIZATION:

A variation of the dichotomous organic versus psychogenic view is a conceptualization that is adhered to by many third-party payers. They suggest that if the physical pathology is insufficient to justify the report of pain, then the complaint is invalid, the result of symptom exaggeration or outright malingering. **Reports of pain without adequate biomedical evidence are assumed to be motivated by secondary, often financial, gain.** This belief has resulted in a number of attempts to identify malingerers using surreptitious observation methods and sophisticated biomechanical machines to identify "inconsistencies" in functional performance.

However, no studies have demonstrated dramatic improvement in pain reports subsequent to receiving disability awards. Remarkably, it has been suggested that it is fear of malingering that drives the entire Social Security Disability System.[5]

OPERANT CONDITIONING CONCEPTUALIZATION:

At this point, it is important to define and differentiate some common but often confused terms. ***Nociception*** **is the activation of sensory transduction in nerves that convey information about tissue damage and thus is a sensory process.** ***Pain***, because it involves conscious awareness, selective abstraction, appraisal, ascribed meaning, and learning, **is best viewed as a perceptual, not purely sensory process.** ***Suffering*** **includes interpersonal disruption, economic distress, occupational problems, psychological distress, and myriad other factors associated with the individual perception of the impact of pain on living.** ***Disability*** **is a complex phenomenon that incorporates the tissue pathology, the personal response to that physical insult, and environmental factors that can serve to maintain the disability and associated pain even after the initial physical cause has resolved.** From this description, it should be apparent that nociception and disability or pain and suffering are **not directly linked**. Rather, the extent of pain, suffering, and much of the disability observed is **associated with an interpretive process.**

The operant conceptualization of pain distinguishes among nociception, pain, suffering, and pain behavior—the first three relating to the private experience of pain and the last being observable, subject to environmental contingencies of reinforcement, and quantifiable.[6] The central tenet of operant conditioning is that **behavior is controlled by its consequences**. Thus, when positive reinforcement

becomes contingent on behavioral manifestations of pain, distress, or suffering, the likelihood is great that pain behaviors will increase in frequency.

Pain behaviors (Table 2) **are viewed as the means by which persons communicate pain and suffering.** Pain behaviors are adaptive at an acute pain level in that they **serve a protective function**. When someone is exposed to a stimulus that causes tissue damage, the behavioral response is withdrawal and **attempts to avoid or escape the noxious sensations to permit healing. This may be accomplished by avoidance of activity believed to cause or exacerbate pain; help seeking to reduce symptoms; and limping, guarding, and bracing by the client. The operant model,** however, does not concern itself with the initial nociceptive stimulus or report of acute pain. Rather it **focuses on pain behaviors that persist even after an initial physical cause of pain has been resolved and that may become problems in their own right.**

Table 2
PAIN BEHAVIORS

- Verbal complaints of pain and suffering nonlanguage, paraverbal sounds (e.g., moans, sighs)
- Body posturing and gesturing (e.g., limping, rubbing a painful body part or area, grimacing)
- Display of functional limitations or impairments (e.g., reclining for excessive periods of time—"downtime")
- Behaviors designed to reduce pain, such as the use of medication or use of the health care system.

The operant conditioning model proposes that pain behaviors are maintained by conditioning and learning. Pain behaviors may be directly reinforced, for example, by significant others who provide attention or permit the client to avoid undesirable activities and thereby unwittingly contribute to the maintenance of such behaviors. Additionally, the disability compensation system may positively reinforce the expression of pain behaviors by providing financial incentives contingent upon the emission of pain behaviors. Also, "well behaviors" (e.g., working) may not be sufficiently reinforced and the more rewarded pain behaviors may, therefore, be maintained.

As already noted, the operant model proposes that **pain behaviors can become the primary problem**. For example, the disabling consequences of bed rest are well known.[7] Inactivity leads to generalized deconditioning (e.g., reduction in muscle strength, tone, flexibility, and easy fatigability).[8] Nociception may then be triggered

when deconditioned muscles are called into action. Also, pain behaviors such as limping, guarding, and bracing can trigger nociception from myofascial syndromes (i.e., muscle inflammation) that develop in muscles not associated with the original injury. Additionally, **continuation of pain behaviors can lead to decreased involvement in previously enjoyed activities and thus increase psychological distress**. In essence, a vicious cycle may be initiated and perpetuated by the unwitting positive reinforcement of pain behaviors.

What differentiates the operant behavioral model from the motivational, secondary gain model described above is the emphasis of third-party payers on conscious motivation. The operant behavioral model **does not imply that pain behaviors are consciously motivated by positive consequences**. According to the operant conditioning model, **pain behaviors may be maintained by reinforcement even in the absence of nociceptive stimulation**. Thus, **this view focuses on the maintenance of pain behaviors and not the etiology of pain**. Behavioral psychologists have suggested that pain is a purely subjective phenomenon and that what should be treated is the client's behaviors in response to pain—not the pain itself. The operant conditioning model has guided the development of a particular treatment intervention approach that is targeted toward **alteration of maladaptive behavior patterns by altering the environmental contingencies of reinforcement** (see below).

Although there exists much support for the view that operant factors can induce or sustain pain behaviors, **considerable caution should be exercised in interpreting the pain behaviors solely as a response to reinforcement contingencies**. Other factors may also be important. For example, evidence shows that frequency of pain behaviors during physical examination is positively correlated with the presence of organic pathology in clients presenting for neurosurgical evaluation.[9]

GATE CONTROL MODEL OF PAIN:

The shift away from the view that pain is a purely sensory phenomenon toward the view that pain is a perceptual event was given great impetus in the mid-1960s by Melzack and colleagues.[10,11] They proposed the gate control model, designed to deal with the inconsistencies in other models of pain and also to incorporate clinical experience.

According to this model, pain is not solely an automatic sensory phenomenon, but "a highly personal, variable experience influenced by cultural learning, the meaning of the situation, attention and other cognitive activities."[12] The gate control model proposed that besides the traditionally recognized dimension of nociception (the sensory-discriminative component of the gate control model), the perception of pain also involved the simultaneous integration of motivational-affective and cognitive-evaluative components.

The view of pain proposed by Melzack and his collaborators[10-12] differed greatly from sensory views that, when they considered psychological factors at all, regarded them merely as reactions to pain and, consequently, nuisance variables and epiphenomena. The gate control model does not give priority to sensory input, nor does it regard sensory input as isomorphic with pain. Rather, pain was postulated to result from the integration and interpretation of sensory and psychological processes and therefore qualified as a perceptual process.

The gate control model also postulated that important physiological pathways were capable of augmenting or diminishing the subjective experience of pain. In addition to afferent neural pathways, some of the proposed pathways involved "top down" processing—the neurophysiological influence of emotions and cognitive phenomena presumably travels down the spinal cord from the brain and can modulate sensory information traveling up the spinal cord toward the brain. Thus, the notion of a "gating" action was proposed, with both physiological and psychological processes capable or modulating the experience of pain by opening and closing the hypothesized gating system.

COGNITIVE-BEHAVIORAL TRANSACTIONAL PERSPECTIVE:

Although both the operant and gate control models depart significantly from the sensory-physiologic models, each has a somewhat limited view and is inadequate in explaining the experience of chronic pain. The operant model fails to consider the role of the client's cognitive appraisal of pain. The gate control model seems more appropriate for acute pain but fails to consider the interactions of environmental influences, physical factors, and pain perceptions and responses *over time*.

Distress in a situation is based in a large part on the way the affected individual perceives the situation. **Clients' perceptions are in turn affected by their expectations**, which are built up from previous experience with illness and medical personnel and what their families, friends, and neighbors have told them, as well as from their individual needs and values. The way in which a person labels or categorizes events and circumstances will color his or her emotional reactions and responses to these events. The extent to which people construe their predicament as beyond their control will serve to compound the problems they encounter.

The variability of client responses to nociceptive stimuli and pain treatments is somewhat more understandable, then, when we consider **pain to be an emotionally charged personal experience influenced by** many factors other than physical pathology, including **attention, mood state, prior learning history, meaning of the situation, and environmental factors. Although specific biomedical factors may precipitate the initial report of pain, in most cases psychosocial and behavioral factors help maintain and exacerbate levels of pain and disability over time**. Therefore, **pain that persists over time should not be viewed as either solely physical or solely psychological**. Rather, the experience of pain is maintained by an interdependent set of biomedical, psychosocial, and behavioral factors,[1,13,14] and a model that focuses on only one of these central sets of factors will inevitably be incomplete.

The cognitive-behavioral transactional perspective suggests that behavior, emotions, and in some cases physiology are influenced by interpretations of events, rather than solely by physiologic factors and characteristics of events ***per se***. According to this model, it is patients' perspectives, based on their idiosyncratic attitudes, beliefs, and unique schema, that filter and interact reciprocally with emotional factors, sensory phenomenon, and behavioral responses. Moreover, clients' behaviors elicit responses from significant others that can reinforce both adaptive and maladaptive modes of thinking, feeling, and behaving. This perspective stands in marked contrast to the purely somatic or psychological views. Similar to the operant perspective, **the most important focus of the cognitive-behavioral perspective is on the client, rather than on only symptoms or pathophysiology**. Unlike the

operant model, however, the cognitive-behavioral perspective places a great deal of emphasis on clients' idiosyncratic beliefs, appraisals, and coping repertoires—as well as sensory, affective, and behavioral contributions—in the formation of pain perceptions.

For chronic pain sufferers, certain ways of thinking and coping are believed to influence the perception of nociception, the distress associated with it, or factors that may increase nociception directly. As an illustration, pain that is interpreted as signifying ongoing tissue damage or life-threatening illness is likely to produce considerably more suffering and behavioral dysfunction than pain viewed as being the result of a minor injury, although the amount of nociceptive input in the two cases may be equivalent. Flor, Turk, and Birbaumer[15] found that when discussing pain or stress, back pain clients had significantly elevated muscle tension in their back, but not in their forehead or forearm. However, when these same clients were resting and not discussing pain or stress, their back muscle tension level was no higher than that of clients not experiencing back pain or healthy individuals. Conversely, neither those clients not experiencing back pain nor healthy persons showed elevations in the electromyographic tension activity of specific back muscles when discussing severe stresses. **In short, back pain clients showed pain-site specific muscular arousal simply by talking about their pain and stress.** Rudy[16] reported similar results for clients with facial pain—temporomandibular disorders.

The studies reviewed in the preceding paragraph focused on the effects of thoughts on the autonomic nervous system. **Cognitive factors also have been shown to have a direct effect of biochemical factors associated with pain.** For example, Bandura and colleagues[17] demonstrated that the efficacy of cognitive coping strategies in studies of laboratory-induced pain can be attenuated by injection of a chemical agent (naloxone [Narcan]), which is known to block the body's production of endogenous opiates (endorphins). Thus, **it appears that psychological factors can directly influence the musculoskeletal system as well as the production of neurotransmitters known to be associated with reports of pain.**

In addition to triggering or aggravating nociception directly, psychological factors also have indirect effects on pain and disability. **Chronic pain sufferers can develop ways of thinking and coping that in the short term seem adaptive but in the long term serve to maintain the chronic pain condition and result in greater disability.**

Because the fear of pain is aversive, the anticipation of pain is a strong motivator for avoidance of situations or behaviors that are expected to produce nociception. Moreover, the belief that pain signals harm further reinforces avoidance of activities believed to cause pain and increase physical damage. Through the process of stimulus or situational generalization, more and more activities are avoided in order to prevent exacerbation of pain. **The undesirable results of this avoidance is greater physical deconditioning and increased disability.**

Inactivity may also lead to preoccupation with the body and pain, and such cognitive-attentional changes **increase the likelihood of amplifying and distorting pain symptoms and perceiving oneself as being disabled. At the same time, the pain sufferer limits opportunities to identify activities that build flexibility, endurance, and strength without the risk of pain or injury. Moreover, distorted movements and postures used to avoid pain can cause further pain unrelated to the initial injury.** For example, when a person limps, he or she protects muscles on one side of the back but may stress the muscles on the other side of the back; this protective action may produce a new painful condition. Thus, avoidance of activity, although it is a seemingly rational way to manage a pain problem, can actually play a large role in increasing and facilitating nociception, the chronic pain condition, and disability when maintained for extended periods.

Chronic pain sufferers often develop negative expectations about their own ability to exert any control over their pain. These negative expectations lead to feelings of frustration and demoralization when "uncontrollable" pain interferes with participation in recreational, occupational, and social activities. **Pain sufferers frequently terminate efforts to develop new strategies to manage pain and instead turn to passive coping strategies such as inactivity, self-medication, or alcohol to reduce emotional distress and pain. They also absolve themselves of personal responsibility for managing their pain and instead rely on family and health care providers,** strategies that may have detrimental consequences. Pain sufferers who feel little personal control over their pain are also likely to "catastrophize" about the impact of pain flare episodes and situations that might initiate or exacerbate pain. **Catastrophizing includes overevaluating and overreacting in a very negative, maladaptive manner,** as if even relatively small problems were major catastrophes. Catastrophizing **has been related to greater pain and suffering and less successful rehabilitation.**[15]

Thus, pain sufferers often develop negative, maladaptive appraisals of their condition and personal efficacy in controlling their pain, thus reinforcing their experience of distress, inactivity, and overreaction to nociceptive stimulation. In contrast, **those who believe they are able to control the situations that contribute to pain flare-ups are more resourceful, are more likely to develop self-management strategies that are effective in limiting the impact of painful episodes, and thus are able to reduce the impact of the pain problem.**

Recent studies have supported the cognitive-behavioral model and demonstrated the important role of cognitive distortions, coping strategies, and self-efficacy in the experience of pain.[1] For example, Reesor and Craig[19] showed that the primary difference between chronic low back pain patients who were referred because of the presence of many "medically incongruent" signs (not consistent with physical pathology identified) and those who did not display these signs was maladaptive thoughts. Interestingly, no significant differences between these groups in the number of surgeries, compensation, litigation status, or employment status was evident. It is possible that these maladaptive cognitive processes themselves amplify or distort clients' experiences of pain and suffering.

Thus, the cognitive activity of chronic pain clients may contribute to the exacerbation, attenuation, or maintenance of pain, pain behavior, affective distress, and dysfunctional adjustment to chronic pain.[14,20] If psychological factors can influence pain in a maladaptive manner, they can also have a positive effect. Those who feel that they have a number of successful methods for coping with pain may suffer less than those who feel helpless and hopeless. Some of the psychological interventions commonly used in the treatment of chronic pain have been shown to be effective in helping people with persistent pain either to eliminate their pain or—if pain cannot be eliminated—to reduce their pain, distress, and suffering. These interventions are designed not only to decrease pain but also to improve physical and psychological functioning.

Psychological Evaluation

Psychological evaluation provides information that is critical to developing an understanding of the client with persistent pain. Regardless of whether an organic basis for pain can be documented or whether psychosocial problems preceded or resulted from pain, the evaluation **can be helpful in identifying how biomedical,**

psychological, and social factors interact to influence the nature, severity, and persistence of pain and disability. Factors such as emotional distress, beliefs about the etiology of pain, and social reinforcement of pain behaviors, which are all important contributors to the maintenance of pain and dysfunction, are also important targets of the assessment[21] (Table 3). If ignored, these psychological factors can impede the client's successful adjustment and rehabilitation.

Table 3
Content Areas Covered in Psychological Interviews

- Secondary problems that have arisen because of persistent pain
- Situational fluctuation of pain
- How the client expresses pain
- How others respond to the client's complaints of pain and disability
- Behavioral manifestations of pain—pain behaviors (moaning, distorted ambulation or posture)
- What effect theclient believes the pain is having on others
- Whether the client derives any benefits from having pain
- How the client thinks about the pain and associated problems
- Pattern of medication use and substance abuse (current and previous)
- Current mood
- What the client has tried to do to alleviate pain
- Client's work history (frequency of changes, satisfaction, does the client have a job to which he or she can/plans to return)
- Client's expectancies from the physician and treatment
- Client's views of previous physicians and treatments
- Prior history of pain problems of client or family members
- Prior and current stressful life events
- Family (marital) relations (current and past)

The primary purposes of a psychological evaluation are to: (a) determine specific psychological and behavioral contributors to pain behaviors, impairment in functioning, and suffering; (b) determine appropriate treatment targets and intervention strategies; and (c) provide pertinent information about aspects of a client's psychosocial history and current situation that may have a bearing on responses to pain. The psychological evaluation helps to draw the distinction between stimuli that are capable of being perceived as pain, pain perception itself, suffering, and disability.

Psychological evaluation can also aid in identifying specific goals for treatment. Clients, their families, and health care providers may be so focused on the alleviation of pain that other related problems go unaddressed. In addition to specific reduction of pain, goals of treatment for chronic pain clients might include increasing activity levels, improved physical and psychosocial functioning, return to gainful employment, and decreasing affective distress and family discord. The evaluation can also clarify the extent to which clients may be receptive to rehabilitation if total elimination of pain is not reasonable and identify potential problems of adherence to self-care recommendations. In addition, the amount and frequency of alcohol, opioid, or sedative-hypnotic medications use is assessed, because excessive substance use complicates both assessment and treatment. Vocational history and factors that might impede return to work are also important, as are litigation issues that may affect assessment and treatment response.

It is inappropriate to use psychological evaluations to: (a) determine if the pain is organic ("real") or functional ("psychogenic"); (b) identify malingerers; (c) justify abandoning difficult clients; or (d) predict a person's response to medical treatment. The last point is especially worth emphasizing. Although some studies in the literature support the utility of psychological assessment for predicting surgical outcome, the precision of those predictions is not sufficient to warrant reliance on psychological assessment in making clinical decisions.[22] **Psychological information must be incorporated with a range of physical and social factors in treatment decision making.**

During an interview, it is essential to adopt the client's perspective. It is important to gather information about clients' appraisals of pain problems and their interpretations about what is happening in their bodies when they are experiencing pain. **Spouses' explanatory models for the cause and implication of pain are similarly important.** In many cases, clients have fears based on misinformation about anatomy and medicine. For example, clients who have been told that they have "degenerative disk disease" may believe that their spine is fragile and unstable, and that movement will hasten the process of degeneration and disability. Those who are told that they have a pinched nerve or slipped disk compressing a nerve may fear damaging the spinal cord and become paralyzed if they increase activity. Those who interpret their persistent pain as a signal of progressive tissue damage understandably avoid activities that increase pain. **Spouses with similar fears are likely to reinforce pain**

behaviors by overprotecting the client and may even sabotage treatment aimed at increasing physical activity.

Assessment should identify any habitual pattern of maladaptive thoughts that contribute to a sense of hopelessness, dysphoria, or unwillingness to engage in activity. In doing so, the assessment focuses on the client's reports of specific thoughts, emotions, behaviors, and physiologic responses that precede, accompany, and follow pain exacerbations. A therapist attends to the temporal association of these cognitive, affective, and behavioral events; their specificity versus generality across situations; and the frequency of their occurrence. This information can assist in the development of potential alternative thoughts, emotions, and behaviors that will minimize pain exacerbations, psychological distress, and disability.

When conducting an evaluation, counselors typically combine a clinical interview with a wide range of assessment instruments to obtain information about psychological functioning. Historically, therapists have **relied on traditional psychiatric assessment instruments, such as the Minnesota Multiphasic Personality Inventory** (MMPI), that were originally developed for use in the treatment of psychiatric problems. More recently, a number of assessment instruments and procedures have been developed specifically for use with persistent pain clients. A recent volume[21] contains a detailed review and description of the most common psychological assessment approaches and instruments used with persistent pain.

In addition to formal interview and self-report questionnaires, therapists should include observations of clients' behavior as part of their assessment. Careful observation may reveal problem behaviors that clients are reluctant to report or of which they may not even be aware. Specific pain behaviors (see Table 2) can be noted unobtrusively while the client ambulates, during the interview, and during discussion of various pain and non-pain related topics. If clients are interviewed with their significant others, the prevalence of pain behaviors can be noted and the responses of significant others to these communications of pain, distress, and suffering can be observed. The responses of significant others are especially important, as they may contribute to the maintenance of clients' maladaptive psychological and behavioral responses.[6]

Therapeutic Interventions

Therapeutic approaches originally used in the treatment of psychological problems have been adapted for use with pain clients.[23] Following is a brief description of some of the modalities and approaches that have received the greatest amount of attention and that have been demonstrated to be most efficacious.

OPERANT CONDITIONING:

Treatments based on operant learning focus on decreasing pain behaviors (e.g., "down time") **and increasing well behaviors** (e.g., engagement in activity) **irrespective of pain levels** (see Table 4). **Important methods of reaching the described goals are withdrawal of attention paid to pain behaviors and attention to and reinforcement of well behaviors. A major component intended to increase well behaviors is physical activity that promotes muscle strength, endurance, and flexibility. Activity is increased by establishing exercise quotas and reinforcing activity with rest, positive feedback, and verbal reinforcement.** Engagement in activity should lead to corrective feedback or reassurance that pain based on movement need not signal injury.

Table 4
GOALS OF OPERANT TREATMENT

- Extinction of pain behaviors
- Promotion and restoration of well behaviors, namely, behaviors that are incompatible with pain behaviors (exercise, work)
- Maintenance of these changes in the client's natural environment (by inclusion of the spouse in the treatment)
- Reduction of pain-related medication, when used, by moving from "as needed" to time-contingent.
- Modification of environmental reinforcement contingencies to accomplish above

At the same time clients are being positively reinforced for activity, pain behaviors are ignored, eventually **leading to the extinction of learned maladaptive behavior patterns. The reinforcing property of medications is diminished by altering medication schedules from an "as needed" basis to an interval basis.** The amount of medication is then reduced on a specific schedule.

To allow better control of the external contingencies of reinforcement, **operant treatment programs are usually conducted on an inpatient basis. Spouse participation is generally required because the spouse is probably the most important**

reinforcer; only he or she can secure transfer of new behavioral patterns to the home environment. **Occupational therapy and physical therapy are usually parts of an operant treatment program because they emphasize increased activity levels.**

Cognitive Reconceptualization and Reconstruction

People are constantly thinking, evaluating, and appraising information about their situation. Meichenbaum[24] emphasized the importance of these internal dialogues. Thoughts can greatly influence mood, behavior, and physiologic processes, and, conversely, mood, behavior, and physiologic activity influence thought processes. Thus, **chronic pain sufferers must become aware of the thoughts, feelings, and behaviors that are associated with their pain and recognize that thoughts can affect psychological functioning, pain responses, and disability.**

The method of cognitive restructuring identifies and modifies stress-inducing thoughts and feelings that are associated with the pain. Cognitive restructuring consists of **six major steps (Table 5)**. Clients are requested to record the thoughts, feelings, and behaviors that are associated with pain or stress episodes. They may be asked to write down: (a) the nature of situations when their pain seems especially high (when, where, who was present, was it a recurrent type of problem or situation); (b) their level of emotional and physiological arousal; and (c) the thoughts they had and the impact of the thoughts on pain perception and emotions.

Table 5
STEPS IN COGNITIVE RESTRUCTURING

1. Verbal set: rationale and overview of the procedure
2. Identification of clients' maladaptive thoughts during difficult situations such as during exacerbations of pain, when emotionally aroused, when feeling stressed
3. Introduction and practice of coping thoughts
4. Shifting from self-defeating to coping thoughts
5. Introduction and practice of positive or reinforcing thoughts
6. Home practice and follow-up

The counselor works collaboratively with the client to link maladaptive, self-defeating thoughts with the client's pain experience. Examples include thoughts such as, "I feel so frustrated and angry with my doctor (employer, family, self, claims adjustor);" "I can't do anything when my pain is bad;" "It is terrible to feel so helpless;" "I feel useless that I

cannot work;" "I don't see how this pain is ever going to get better;" "I shouldn't have to live this way." **These maladaptive thoughts typically fall within a common set of *cognitive errors* that affect pain perceptions and disability. A cognitive error may be defined as a negatively distorted belief about oneself, one's situation, or the future.** Lefebvre[25] found that chronic low back pain patients were particularly prone to cognitive errors such as "catastrophizing," "over-generalizations" (assuming that the outcome of one event necessarily applied to the outcome of future or similar events); "personalization" (interpreting negative events as reflecting idiosyncratic meaning or personal responsibility); and "selective abstraction" (selectively attending to negative aspects of experiences).

Cognitive errors, frequently observed in chronic pain sufferers, can be related to emotional difficulties associated with living with pain. **Flor and Turk[26] found that variability in pain report and disability in chronic pain sufferers was accounted for by maladaptive thoughts; in contrast, physical factors contributed very little to self-reports of pain and disability.** Some have suggested that the most important factor in poor coping is the presence of catastrophizing, rather than differences in the nature of specific adaptive coping strategies. Turk, Meichenbaum, and Genest[27] concluded that "what appears to distinguish low from high pain tolerant individuals is their cognitive processing, catastrophizing thoughts and feelings that precede, accompany, and follow aversive stimulation..." (p. 197).

Once cognitive errors that contribute to pain perception, emotional distress, and disability are identified, they become the targets of intervention. Clients are usually asked to generate alternative, adaptive ways of thinking and responding to minimize stress and dysfunction (e.g., "I'll just take one day at a time;" "I'll try to relax and calm myself down;" "Getting angry doesn't accomplish anything, I'll try to explain how I feel"). **Clients should be asked to practice these alternatives at home and to review them during therapy sessions.** The therapist will also encourage clients in their efforts and suggest that they should positively reinforce themselves for the effort and not necessarily for the result, as changing habitual ways of thinking can take time.

In a study of recurrent headache sufferers, Holroyd, Andrasik, and Westbrook[28] showed that cognitive restructuring yielded improvements in headaches ranging from 43% to 100%. In the headache population, cognitive restructuring has been

shown to be more effective when combined with progressive relaxation training, yielding improvements that are somewhat more effective than drug therapy with amitriptyline (Elavil).[29]

PROBLEM SOLVING:

An approach that is closely aligned with and incorporated into cognitive restructuring is problem solving. Problem solving consists of six steps, each of which is related to specific questions or actions (Table 6). An important first step is to identify the situations that are associated with pain. Self-monitoring can help identify the links between thoughts, feelings, and pain, and thereby identify the problem. Once a set of problems has been identified, the client can begin to create a set of solutions, then evaluate the likely outcomes in implementing each possible solution. Clients may then try their strategy and evaluate the outcome. If they are not satisfied with the first strategy, they can review the other options that they generated and decide to try another possible solution. No one solution is perfect, but some are more effective than others at a particular point in time. By using problem solving strategies, a person can target the situations that trigger the muscle tension associated with the pain. After using successful problem solving approaches, confidence in his or her ability to handle stressful situations can grow.

Table 6
PROBLEM-SOLVING STEPS, QUESTIONS, AND ACTIONS

Steps	*Questions/Actions*
Problem identification	What is the concern?
Goal selection	What do I want?
Generation of alternatives	What can I do?
Decision making	What is my decision?
Implementation	Do it!
Evaluation	Did it work? If not, recycle

SELF-MANAGEMENT STRATEGIES:

Any of a number of techniques can be used to assist clients in living with pain while reducing suffering and disability. These strategies or skills can be broadly categorized as self-management and are used to help clients control and manage pain, the

factors that trigger pain, and the distress associated with the pain. Some are **self-regulatory skills** (e.g., relaxation training, biofeedback, and distraction) that allow the pain sufferer to control the physiologic responses that may be involved in pain production. Other self-management strategies include **stress-management skills** that permit the pain sufferer to manage effectively the stress-inducing thoughts, behaviors, and emotions that trigger pain responses. With self-management strategies, instead of being a passive recipient of a medical intervention (such as medication or anesthetic nerve block), the **client plays an active role in learning and applying skills to manage the pain and associated problems**.

The potential benefits from the use of self-management strategies are many. As clients learn to self-regulate physiologic responses and manage stressful situations, they can **develop an increased sense of personal control over the pain and the factors that influence pain**. In addition, unnecessary medication consumption that can produce adverse effects can be reduced while appropriate doses of medication can be continued.

Relaxation:

Perhaps the **most common, practical technique** to control pain is muscle relaxation. Because many pain problems have musculoskeletal or neuromuscular components, learning to reduce and control muscle tension can be effective for several reasons. If pain is caused by muscle spasm, muscle relaxation procedures may be effective in reducing pain by decreasing or preventing spasm. In addition, **relaxation procedures may help control other mechanisms that are involved in pain production**.[13] Engaging in muscle relaxation may also **reduce the anxiety and distress** that accompany persistent pain or trigger pain episodes. Relaxation can **improve sleep**, which may have secondary benefits: it is much easier to cope when rested than fatigued from lack of sleep. Muscle relaxation may also help clients distract themselves from the nociception.

There are **many types** of relaxation, and **no one "best" approach** has been demonstrated. Clients can learn different approaches in order to find one that is most useful; with assistance, most will be able to find several effective methods of relaxation.

Biofeedback:

Biofeedback procedures allow persistent pain sufferers to exert some control over physiologic processes, such as muscle tension, of which they have only

marginal awareness and over which they may feel they have little control. Quite simply, **biofeedback equipment converts the readings of physiologic responses into visual or auditory signals that the person uses to develop voluntary control of the physiologic response. The machine only provides information; it is the client who changes the physiologic activity.**

Two types of biofeedback procedures are commonly used for pain problems. The **most common type is electromyographic (EMG) biofeedback**. EMG biofeedback **monitors electrical activity from muscle tension,** allowing the client to become aware of and control muscle tension that contributes to pain. **Thermal biofeedback, which is most frequently used in the treatment of migraine, monitors skin temperature** (usually from a finger), as an indication of changes in peripheral blood flow.

After developing control over physiologic response in the biofeedback lab, clients can practice and apply the techniques in situations where they are most relevant. With practice most people can learn to control voluntarily important physiologic functions that may be associated directly with pain and stress.

The mechanisms by which biofeedback produces its positive effects are unknown.[30] When first developed, many investigators and clinicians believed biofeedback directly reduced maladaptive physiological processes that contributed to pain. However, several studies have demonstrated that biofeedback can be beneficial when no physical changes occur, or even when clients learn to increase levels of muscle tension.[31,32] One possible explanation is that for some persons the biofeedback actually leads to reduction in maladaptive physiologic activity, whereas for others, biofeedback only instills the belief that they can exert some control over their bodies and their symptoms. This belief may lead to other coping changes that reduce emotional distress and ameliorate the pain problem. Regardless of the mechanism, biofeedback, usually in conjunction with other modalities such as cognitive restructuring, appears to benefit some chronic pain sufferers.

COPING SKILLS TRAINING:

Coping is assumed to be manifested by spontaneously employed purposeful and intentional acts, and it can be assessed in terms of covert and overt behaviors. **Overt behavioral coping strategies include rest, medication, and use of relaxation. Covert coping strategies include various means of distracting oneself from pain,**

reassuring oneself about his or her own capabilities or about the likelihood that the pain will diminish, and seeking information. Coping strategies are thought to alter both the perceived intensity of pain and the ability to tolerate pain while continuing daily activities.[27]

Studies have suggested that no one coping skill to manage pain and disability is best.[33] Rather than teaching clients a specific set of coping strategies, it may be more helpful for the client to learn to use many and then use them as needed and in combination. Regardless of the coping skill used, the emphasis should be on self-control and resourcefulness as opposed to helplessness and passivity.

As recently reviewed,[33] many studies have demonstrated that instruction in adaptive coping strategies can lead to a decline in pain intensity and increase in pain tolerance. For example, Turner and Clancy[18] showed that during cognitive-behavioral treatment, reductions in catastrophizing and other cognitive distortions were significantly related to reductions in pain as well as disability in chronic low back pain clients.

Interdisciplinary Pain Clinics

Interdisciplinary pain clinics develop and implement a comprehensive treatment plan that is individualized to the specific physical and psychological needs of the pain client. Most persons with persistent pain are treated by primary care physicians and are never seen at pain clinics. Examination of the literature suggests certain client characteristics predispose them to be referred to pain clinics (Table 7).[34] Thus, it is important to acknowledge that the literature based on clients treated at pain clinics may not be completely generalizable to clients evaluated and treated in primary care settings.

Treatment regimens at interdisciplinary pain clinics can vary in duration from several weeks to several months and may be conducted on an

Table 7
CHARACTERISTICS OF CLIENTS REFERRED TO PAIN CLINICS

- Report high levels of psychological distress
- Display high levels of psychopathology
- Report high levels of functional impairment
- Have work-related injuries
- Have low levels of education
- Report frequent use of the health care system
- Complain of constant pain with few pain-free periods
- Have undergone prior surgery(ies) for pain
- Are currently using narcotic medication

inpatient or outpatient basis. Treatments at such clinics will vary but will usually include **active physical therapy** designed to increase muscle strength, tone, and flexibility and also improve body mechanics (how one moves during activities such as lifting). **Occupational therapy will focus largely on activities of daily living, including homemaking activities, occupation-related activities, and pacing of activities.** The therapist will teach many of the self-management techniques discussed above as well as work on improving communication with family and health care providers. Physicians and nurses will identify physical limitations, monitor medication, and improve aspects of healthy living (e.g., diet, use of alcohol, sleep).

Recent research reviewed by Flor, Fydrich, and Turk[35] suggests treatment in an interdisciplinary pain clinic can lead to significant and dramatic improvements in pain, physical functioning, and psychological distress. This is not to say that pain will be completely eliminated, but it can be significantly reduced, and the person will be able to function better, both physically and emotionally, with a significant percent of clients returning to gainful employment.

Conclusion

A significant proportion of Americans experience chronic pain. For many, the cause of the pain cannot be identified and medical treatments are not available to eliminate the pain. Many feel helpless and hopeless, and those beliefs can actually worsen the pain experienced. Although psychological factors rarely cause the pain, they can trigger and exacerbate a pain episode, help maintain the pain disorder, and contribute to the distress and disability experienced with chronic pain conditions. Counselors can play an important role in both the assessment and treatment of clients with persistent pain.

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Questions Based on This Lesson

9. Which of the following assumptions is made by the psychogenic model of pain conceptualization?
   A. Reports of pain that lack biomedical corroboration are motivated by financial gain
   B. Pain severity is directly proportionate to the amount of tissue damage
   C. No individual differences other than psychopathological ones influence pain perception
   D. Normative data are not available for pain syndromes in order to assess excess in a client's report of persistent pain

10. Nociception:
   A. Is medical nomenclature used to describe muscle inflammation
   B. Can be triggered in back pain sufferers simply by having them talk about their pain and stress
   C. Is a side effect commonly seen in chronic headache suffers who undergo pharmacotherapy with amitriptyline (Elavil)
   D. Unlike pain, should be viewed as a perceptual, not purely sensory process

11. Which of the following statements about psychological evaluations for chronic pain clients is correct?
   A. The evaluations have the ability to clarify the extent to which a client may be receptive to rehabilitation
   B. During the evaluation, the therapist should remain independent of and not adopt the client's perspective
   C. It is appropriate to use such evaluations to determine whether pain is real versus functional
   D. To eliminate any inherent bias, therapists should avoid including their own observations of the client's behavior in the assessment part of the evaluation

12. Which of the following therapeutic interventions for persistent pain focuses on decreasing pain behaviors?
   A. Coping skills training
   B. Operant conditioning
   C. Cognitive reconceptualization
   D. Problem solving

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 4

Aggression Replacement Training in Children and Adolescents

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Editor's Note

Aggression is learned from a very young age. A 1987 study of television programming observed an average of 13 violent acts per hour during prime time hours, and 32 such acts per hour during Saturday morning cartoons. Whether such programming leads conclusively and inevitably to youth aggression has not been determined, but it nevertheless represents a societal validation of these acts, at least on some level. Moreover, many youth have no access to positive role models or environments that in any way teach or reinforce constructive behavior; thus, many fail to develop such behavior.

Aggressive youth are characteristically lacking in personal, interpersonal, and social cognitive skills that collectively constitute effective prosocial behavior. They are less likely to negotiate and compromise, or otherwise respond appropriately to conflict. They lack the skills necessary to deal with frustration, relying instead on impulsive and aggressive means for goal attainment; and they tend to possess more egocentric, concrete, and primitive levels of moral reasoning.

To deal with the problems of youth violence, Dr. Glick and colleagues have developed a unique program, Aggression Replacement Training (ART), which has been implemented worldwide in the rehabilitation of aggressive youth. ART is a differential intervention program that seeks to retrain youngsters in appropriate social skills, anger control, and moral reasoning. The program consists of three components: Structured Learning Training (SLT), Anger Control Training (ACT), and Moral Education (ME). SLT is a 50-skill curriculum that teaches social skills through modeling, role playing, performance feedback, and transfer training. ACT teaches youth to internally monitor and control violent responses by identifying triggers and cues to anger, and using reminders, reducers, and self-evaluation. ME, employed in a discussion group context, is designed to increase the level of moral reasoning used when evaluating an aggression-provoking situation.

This lesson introduces the rehabilitation counselor to ART and explains many of the methodologies employed so that they may be replicated and used in a variety of treatment settings.

Introduction

***Aggression**: any action an individual takes against another person that results in injury; or any action an individual takes against property that results in damage.*

We live in an aggressive and violent society. While most of us do not fancy ourselves as hostile or aggressive—certainly not violent—we do indeed exist in a basically hostile world. We teach aggression to our youngsters in our homes, in our churches, in our schools. **Aggression pays!** Americans learn at a very early age that **aggression is immediately, richly, effectively, and efficiently rewarded**. Furthermore, most of us experience various forms of aggression so frequently that **we are desensitized to its effects on our own growth, perceptions, values, and attitudes**. Conditions that promote aggression are summarized in Table 1.

Table 1
CONDITIONS THAT PROMOTE AGGRESSION

- Weak familial or social bonding
- Being a frequent target of aggression
- Observation of successful acts of aggression
- Positive reinforcement of aggressive acts
- Deficiency in information processing skills
    - Ability to identify means-ends relationships
    - Ability to generate alternative solutions
    - Ability to generate consequences
    - Overattribution of hostile intentions
    - Belief that aggression is legitimate behavior
    - Belief that aggression increases self-esteem
    - Belief that aggression yields positive tangible results for self and significant others
- Deficiency in moral reasoning (the capacity to view the world in terms of justice and fairness)
- Deficiency in identifying and using alternative prosocial skill competencies in anger-producing situations

The Sociology of Aggression

Aggression and hostility are so prevalent in our society that by the time a child reaches adolescence, **chances are he or she will commit some act of delinquency within two years of the onset of puberty**. Even though the youth population has declined, the rate of juvenile delinquency and youth aggression has increased and has become even more severe. Juvenile arrests grew 300% from 1975 through 1978 (Table 2), almost twice the adult criminal rate. Males were more delinquent than females at a rate of 4:1.

The most frequent violent crime committed by males is robbery; for females, it is aggravated assault. The average age for a first arrest is 13 years. African-American youth are arrested five times more than white youth (violent crimes, 3:1; and theft, 11:1). Juvenile aggression is more likely to occur in urban rather than rural settings. Juveniles are more likely to act in groups, less likely to use a gun, and equally likely to use a knife or some other weapon. The victim of juvenile criminal aggression is seven times more likely to be another juvenile, female rather than male, older rather than younger, a person of color rather than white, poor rather than wealthy, and previously known to the perpetrator.

Table 2
JUVENILE ARRESTS
(FBI CRIME INCIDENTS REPORT, 1975–1978)

Crime	Increase (%)
Total arrests	300
Robbery	376
Aggravated assault	249
Homicide	211

The Psychology of Adolescent Aggression

Recent research reveals **four primary traits** that are characteristic of aggressive youth: **verbal and physical aggression, skill deficiency, immaturity,** and **withdrawal**.

VERBAL AND PHYSICAL AGGRESSION:

Quay[1] studied adolescent behaviors using multivariate analysis, and developed a classification for aggressive children. He found that aggressive children could be identified by such behaviors as **fighting, disruptiveness, profanity, irritability, quarrelsomeness, defiance of authority, irresponsibility, high levels of attention-seeking, and low levels of guilt feelings**. Quay observed active antisocial aggressiveness that resulted in conflict with parents, peers, and social institutions.

SKILL DEFICIENCY:

Most behaviorally disordered (aggressive) adolescents are skill-deficient. That is, they **have not developed the social skills necessary to successfully negotiate their environments.**

IMMATURITY:

These behaviors include **short attention span, clumsiness, preference for younger playmates, passivity, daydreaming, and incompetence. Immaturity often leads to alienation from peers**. By definition, these behaviors represent patterns that may have been appropriate at earlier stages of development, but are not acceptable for the adolescent. In the case of conduct disorders, immaturity leads to attacks on others or withdrawal (in the cases of personality disorders).

WITHDRAWAL:

Behaviors linked to withdrawal have been variously labeled as "personality problem,"[2] "disturbed neurotic,"[1] and "overinhibited," and are characterized by **depression, feelings of inferiority, self-consciousness, shyness, anxiety, hypersensitivity, seclusiveness, and timidity**. While withdrawal is not ordinarily associated with aggression, it certainly lends itself to the aggressive adolescent, and is often clinically diagnosed as a component of the passive-aggressive personality.

Aggression Replacement Training (ART): A Multi-Modal Response

Effective intervention is **differential intervention**. Differential interventions ensure that an array of services and programs are available to the aggressive child and adolescent. Once sufficient programming is available, this hypothesis states that different children and adolescents will respond to different rehabilitation methods. The central question that must be addressed in prescriptive programming for the aggressive juvenile is: **Which types of youth, meeting with which types of change agents, for which types of interventions, will yield optimal outcomes?**

Any and every act of aggression has multiple causes, both within and external to the child or adolescent. With regard to internal causes, ample evidence exists to support the belief that **aggressive youth frequently possess a series of interlocking and often reciprocally compounding deficiencies**. They characteristically are weak or lacking in much of the broad array of personal, interpersonal, and social cognitive skills that collectively constitute effective prosocial behavior. Indeed, a major portion of the disruptiveness and overt aggression reflects psychological and social skill deficiencies. **Persons with skill deficiencies often are weak or lack the knowledge and ability to ask rather than**

demand. Likewise, they are less likely to negotiate and compromise, or otherwise respond appropriately to conflict rather than strike out physically. Moreover, these youth lack the skills necessary to handle frustration; to respond effectively to the complaints, anger, instructions, or accusations of others; or to behave competently in other important personal and interpersonal arenas. Their frequent impulsiveness and overreliance on aggressive means for goal attainment often reflect a deficiency in anger control.

In the cognitive realm, **aggressive youth** have consistently been shown to **reason at more egocentric, concrete, and primitive levels of moral reasoning**. Although there are many other internal and external antecedents of aggressive behavior than those we address in Aggression Replacement Training (ART), we predicted that much of the outcome variance associated with efforts to change such behavior would occur in the domains of **enhanced prosocial skill proficiency**, **heightened anger control**, and **more advanced levels of moral reasoning**.

ART Research and Evaluation

The ART plan developed by Glick and Goldstein[3] has become a significant intervention for aggressive, acting-out children and adolescents. Since the original program, ART has been evaluated independently in several jurisdictions with comparable results.

We developed and implemented ART at Annsville Youth Center, a New York State Division for Youth residential facility for boys who range in age from 14–17 years. They had committed such crimes as assault, burglary, auto theft, possession of stolen property, criminal trespass, and drug use. Annsville is situated in a rural area of New York State, and occupies 30 acres of a 100-acre reserve formerly used as a state forestry camp. At the time of the project, 60 young men were in residence. The median age was 15; the ethnic background of the group was 50% African-American, 40% Caucasian, 8% Latino, and 1%

Native American. Approximately half came from New York City, the other half from the rest of the state.

The research plan first involved pretesting the population of 60 boys in a dormitory area that was organized in 5 units of 12 boys each. Units were randomly assigned to experimental and appropriate control conditions. We posttested the boys to ascertain change, and then internally replicated the test for efficacy by providing ART to those youngsters who had been in the control groups, to see if they, too, changed on the several outcome measures. This overall evaluation sequence subsequently was replicated in its entirety, involving a maximum security center for youth incarcerated for such crimes as murder, rape, manslaughter, sodomy, arson, and aggravated assault. The program then was designed to be implemented in the community for youth who were returning to their communities on aftercare status (parole-type services) and who were being evaluated there as well.

The five units were randomly assigned to three evaluation conditions. Two units (condition 1) were assigned to a full course of ART, which is comprised of three basic components: **Structured Learning Training** (SLT), **Anger Control Training** (ACT), and **Moral Education** (ME). The 24 youths, in groups of six each (all groups came from within—never across—units) for SLT and ACT, and 12 each for ME, met for 30 classes over 10 weeks. **Two other units, also a total of 24 youths, were assigned to a "brief instructions" control group** (condition 2). This condition was designed to control for the effects of trainee motivation; that is, changes in a more skilled direction should not be attributed to ART unless such changes can be shown to exceed those associated with simple motivational enhancement. **The 24 youngsters assigned to the "brief instructions" control group were pretested, participated only in usual facility activities—not ART—and then were posttested 10 weeks later at the same point in time as youngsters who received ART.** Just prior to their posttest, however, the "brief instructions" youngsters were provided with test instructions designed to enhance their display of skilled behavior;

i.e., instructions about the nature, value, and utility of the skills involved, and especially the desirability of reflecting these skills in their posttest responses.

An important intervention evaluation question one may pose is **whether the intervention is superior in its effect to no intervention at all**. The answer to this question is made possible by the "no treatment" control group. Thus, 12 youngsters (one unit) were assigned to this condition and received pretesting and posttesting only, with no ART intervention or motivational instructions.

We provided all youngsters with a battery of tests to capture the types of behaviors possible as a result of ART. Project data were analyzed by means of a series of 1 x 3 analyses of covariance, controlling for initial status on each variable examined. We found that **youngsters who completed ART, in comparison to those who experienced either motivation enhancing but no training experience, or no training, changed significantly on all study outcome criteria. They both acquire and transfer structured learning skills to a degree significantly beyond that acquired and transferred by control-conditioned youth. ART youngsters also change significantly for the better in their own behavior in the facility**. In terms of both the number of acting-out incidents and the intensity of those that did occur, ART youngsters performed significantly better than controls.

Our community program enhanced our knowledge of dealing with aggressive children and adolescents. We found that **ART youth recidivated less than those who did not undergo ART**. We also found that **youth who participated with their significant others dramatically reduced their risk of recidivism over a 6-month period**.[4]

Structured Learning Training (SLT)

Structured Learning Training (SLT) is a psychoeducational intervention designed by Glick and Goldstein[3] in which a **50-skill curriculum of prosocial behaviors is systematically taught to small groups of chronically aggressive adolescents** (Table 3). The SLT

Table 3
THE STRUCTURED LEARNING SKILL CURRICULUM

GROUP I: BEGINNING SOCIAL SKILLS

1. Listening
2. Starting a conversation
3. Having a conversation
4. Asking a question
5. Saying "thank you"
6. Introducing yourself
7. Introducing other people
8. Giving a complaint

GROUP II: ADVANCED SOCIAL SKILLS

9. Asking for help
10. Joining in
11. Giving instructions
12. Following instructions
13. Apologizing
14. Convincing others

GROUP III: SKILLS DEALING WITH FEELINGS

15. Knowing your feelings
16. Expressing your feelings
17. Understanding the feelings of others
18. Dealing with someone else's anger
19. Expressing affection
20. Dealing with fear
21. Rewarding yourself

GROUP IV: SKILL ALTERNATIVES TO AGGRESSION

22. Asking permission
23. Sharing something
24. Helping others
25. Negotiation
26. Using self-control
27. Standing up for your rights
28. Responding to teasing
29. Avoiding trouble with others
30. Keeping out of fights

GROUP V: SKILLS FOR DEALING WITH STRESS

31. Making a complaint
32. Answering a complaint
33. Sportsmanship after the game
34. Dealing with embarrassment
35. Dealing with being left out
36. Standing up for a friend
37. Responding to persuasion
38. Responding to failure
39. Dealing with contradictory messages
40. Dealing with an accusation
41. Getting ready for a difficult conversation
42. Dealing with group pressure

GROUP VI: PLANNING SKILLS

43. Deciding on something to do
44. Deciding what caused a problem
45. Setting a goal
46. Deciding on your abilities
47. Gathering information
48. Arranging problems by importance
49. Making a decision
50. Concentrating on a task

curriculum is preferably implemented with 6–8 adolescents in a group.

The techniques we use to teach children and adolescents social skills training are founded upon sound pedagogy that is used to teach any behavioral skill. If I wanted to teach my 17-year-old son how to drive, I would first take him into my car and *show* him (modeling) how to place the key in the ignition, ensure the car was in neutral, turn on the ignition, and coordinate the flow of gas with the raising of the clutch so as to properly engage the car into first gear, and so on. I would then ask him to *try* (role playing) what he was shown. I would then provide an opportunity for *discussion* (performance feedback), to give constructive criticism of his performance. Finally, I would give him an opportunity to *practice* (transfer training) what he had learned. We do nothing more when facilitating both the skill training and anger control components of SLT.

MODELING:

Modeling exercises serve to demonstrate examples of expert use of behaviors constituting the skills in which the youngsters are weak or lacking. During the modeling sequence, the facilitator ensures that **the modeling display is presented to trainees in a clear and unambiguous manner**. The display should depict the behavioral steps that constitute the skill being taught. **All the steps that make up the skill should be modeled in their correct sequence**. Modeling consists of **live vignettes enacted by the trainers.** Audio or visual tapes may be substituted as the modeling display, although it is not as effective as live demonstrations. The trainers should always rehearse the vignettes prior to each session and ensure that all the skill's steps are in proper sequence and enacted correctly. **Modeling displays should incorporate at least two examples of different situations for each skill being demonstrated**. If a given skill is taught in more than one group meeting, the facilitator should develop the corresponding number of modeling displays, taking care to select situations relevant to the trainees' real-life circumstances. The main

actor (the person enacting the behavioral steps of the skill) should be portrayed as a person who is reasonably similar in age, socioeconomic background, verbal ability, etc., to the participants in the structured learning group.

For clarity and ease of understanding, **modeling displays should depict only one skill at a time** and should depict **all behavioral steps of the skill in the correct sequence**; all extraneous content should be eliminated. It is also important that **all displays depict positive outcomes**. As the modeling display is performed by the trainers, "skill cards," (pocket-sized cards given to each group member to carry with them during the week to refer to as they practice their assignments), which contain the name of the skill and its steps, are distributed prior to the modeling display. Trainees are told to watch and listen carefully as the models portray the skill. The trainer/facilitator tells the group that sometimes, in order to depict some of the behavioral steps in certain skills, the actors will occasionally be "thinking out loud" statements that would ordinarily be thought silently.

ROLE PLAYING:

Role playing provides several guided opportunities to practice and rehearse competent interpersonal behaviors. Role playing should immediately follow the modeling display, and should relate the modeled skill to the lives of the trainees. First, invite comments on the behavioral steps and how these steps might be useful in real-life situations that the trainees themselves might encounter. Second, focus on current and future skill use rather than only past events or general issues that involve the skill.

Once a trainee describes a situation in which the skill would be useful, that person is designated the "main actor." The trainee selects a second trainee as a "co-actor" to play the role of the other person in their life who is relevant to the situation (e.g., mother, peer, staff member, etc.). Be sure to **encourage the trainee to choose someone that resembles the**

real-life person in as many ways as possible (e.g., physically, expressively). Then, solicit additional information to set the stage for the role playing; i.e., a description of the physical setting, events immediately preceding the role play, a description of the manner that the co-actor should display, and any other information to **increase a sense of reality**.

The facilitator/trainer should **review the steps of the skill with the actor** and make sure the actor understands how the steps are to be applied to the role play. Tell the actor to refer to the skill card and assign other group members to watch the role playing and ensure that the steps are being completed. The trainer should ensure that the co-actor stays in his or her role, and also coaches the observers on the cues to watch by his or her posture, tone of voice, and content of speech. The facilitator may break the role playing and start again, giving the necessary instruction or reinstruction before restarting. (Remember, **in Aggression Replacement Training, we are interested in *practice of perfect, not "practice makes perfect."*) One facilitator/trainer should be positioned near the chalk board pointing out each step as it is role-played. A second facilitator/trainer should be strategically seated with the group to help the members with the tasks at hand or to maintain order**. Role playing continues until all participants have an opportunity to be a main actor. Sound group role-playing techniques can be employed, such as "role reversal" (where the actor and co-actor switch roles); with hesitant clients, the trainer may assume the role of the co-actor.

PERFORMANCE FEEDBACK:

Performance feedback is a discussion period that provides praise, reinstruction, and related feedback on how well the adolescent's role playing of the skill matched the expert model's portrayal of it. It also examines the psychological impact of the enactment on the co-actor and provides the main actor with encouragement to try out the role-played behaviors in real-life situations. The facilitator first should ask the co-actor about his or her reactions, then have the observers comment on how well the behav-

ioral steps were followed. Next, trainers should comment on how well the behavioral steps were followed and provide social reinforcement (praise, approval, encouragement). During this activity, the facilitator should **follow sound reinforcement techniques** as in any good behavioral feedback session. That is, **provide reinforcement only after role plays that follow the behavioral steps**, and **at the earliest appropriate opportunity**; **vary the specific content of the reinforcements.** For example, praise particular aspects of the performance such as the tone of voice, posture, and phrasing; provide enough role playing activity for each group member to have sufficient opportunity to be reinforced; provide reinforcement in an amount consistent with the quality of the given role play; **provide no reinforcement when the role playing departs significantly from the behavioral steps** (except for "trying" in the first session or two); provide reinforcement for an individual trainee's improvement over previous performances; and always provide reinforcement to the co-actor for being helpful, cooperative, and willing to try. The trainer should focus on behavioral structured learning components. **Comments should reflect concrete behaviors, not general evaluations**. Negative comments should always be followed by a constructive comment as to how a skill or step should be improved. Poor performance may be reinforced simply by saying, "Good try." Trainees who fail to follow the behavioral steps of the skill should be given the opportunity to role play the same behavioral steps after receiving corrective feedback.

TRANSFER TRAINING:

Transfer training, or practicing, encourages youth to engage in a series of activities designed to increase the chances that the skill learned in the training setting will endure and be available for use when needed in the environment, whether it be the institution, home, school, community, or other real setting. The general principles to implement transfer training start with the trainer **providing the trainees elementary**

understanding of basic stimulus-response relationships operating in the training and real-world environments. Thus, one should provide the trainees' information visually, verbally, and in writing. Three principles that are particularly useful in transfer training are: overlearning, identical elements, and positive transfer.

***Overlearning*:**

Overlearning involves training in a skill beyond what is necessary to produce initial changes in behavior. In both structured learning and anger control groups, overlearning is substantial for each skill taught. Its behavioral steps are **modeled several times, role played one or more times by the trainees, observed live by the trainee as every other group member role plays, read by the trainee from a chalk board and a skill card, and practiced in real-life settings** one or more times by the trainee as part of the formal homework assignments.

***Identical Elements*:**

Another principle involved in transfer training is what we call **"identical elements." The greater the similarity of physical and interpersonal stimuli in the group setting**, as well as the homework and community or other setting in which the skill is to be applied, **the greater the likelihood of transfer**. The trainer may ensure that the structured learning or anger control setting is more similar to real life settings by: **designing the live modeling displays to be highly similar to what trainees face in their daily lives** through the representative, relevant, and realistic portrayal of the models, protagonists, and situations; **designing the role playing to be similar to real-life situations** through the use of props, the physical arrangement of the setting, and the choice of realistic co-actors; **conducting the role-playing to be as responsive as possible to the real-life interpersonal stimuli to which the trainees must actually respond later with the given skill**; **rehearsing each skill** in role plays as the trainees actually plan to use it; and **assigning homework**.

Positive Transfer:

Positive transfer of skills is greater when a *variety* of relevant training stimuli are employed; we call this **"stimulus variability."** To apply this principle to structured learning and anger control groups, one should **rotate group leaders** across groups, **rotate trainees** across groups, **role play a given skill with several different co-actors, role play a given skill by trainees across several relevant settings**, and **complete multiple homework assignments** for each given skill.

Anger Control Training (ACT)

Anger Control Training (ACT) was first developed by Feindler, Marriott, and Iwata,[5] and was partially based on the earlier anger control and stress inoculation research of Novaco[6] and Meichenbaum.[7] The goal is to **teach youngsters the inhibition of violent responses**. In ACT, each young person is required to bring to each session a description of a recent anger-arousing experience (a hassle), which they record in a binder (their hassle log). For 10 weeks, **the youngsters are trained to respond to their hassles** with a chain of behaviors that include:

- **identifying triggers** (external events and internal self-statements that provoke anger responses)
- **identifying cues** (individual physical events such as tightened muscles, flushed face, and clenched fists that let the child or adolescent know that the emotion he or she is experiencing is anger)
- **using reminders** (self-statements such as "stay calm," "chill out," "cool down," or non-hostile explanations of others' behavior)
- **using reducers** (a series of techniques that, like the use of reminders, is **designed expressly to lower the individual's level of anger**—such as deep breathing, counting backward, imagining a peaceful scene, or imagining the long-term consequences of one's behavior)

- **using self-evaluation (reflecting on how well the hassle was responded to** by identifying triggers, identifying cues, using reminders, and using reducers; and then **praising or rewarding oneself for effective performance**)

Young people who have participated in SLT and ACT are knowledgeable about what to do and what not to do in circumstances that instigate aggression. However, because aggressive behavior is so consistently rewarded in many of the real-world settings in which children and adolescents live, work, go to school, and interact, **they may still consciously choose to behave aggressively**. Thus, we believed it was important to add a values-oriented component to the intervention approach that they were developing and evaluating.

Moral Education (ME)

The Moral Education (ME) component of Aggression Replacement Training is a set of procedures designed to **raise the young person's level of fairness, justice, and concern with the needs and rights of others**. In a long and pioneering series of investigations, Kohlberg[8,9] demonstrated that exposing youngsters to a series of moral dilemmas (in a discussion group context in which youngsters reason at differing levels of moral thinking) arouses an experience of cognitive conflict, the resolution of which will frequently advance a youngster's reasoning in the group. Such advancement of moral reasoning is a reliable finding, but, as with other single-enhancing interventions, efforts to use it alone as a means of actual, overt moral behavior have resulted in only mixed success.[10,11] We suggest a need for increasing adolescents' levels of moral reasoning because **such youth did not have in their behavioral repertoires either the actual skills for acting prosocially or for successfully inhibiting antisocial or more aggressive behaviors**. Thus, we reasoned that Kohlberg's Moral Education has marked potential to provide constructive direction toward sociability and away from antisocial behavior.

Two trainers meet with at least 12 youngsters in each ME group. Once the groups are formed, **trainers must choose and prepare the moral dilemmas, create a proper environment and attitude, initiate the discussion, guide the discussion, and then end the discussion**. Facilitators are trained to accomplish each of these procedural steps so they may accomplish the following:

***Choose and Prepare a Dilemma*:**

The trainer first should **anticipate how the participants will reason at each stage**. Second, the trainers should **prepare elaborations to generate disagreements** for each dilemma. And finally, the trainers should **prepare at least two counterarguments** for how to deal with the dilemma.

***Create the Proper Environment and Attitude*:**

The facilitator should **ensure that the group is physically and psychologically safe** and secure enough for the participants to share ideas and beliefs openly. The facilitator should then **identify the goals of the group**; i.e., provide explanations for the purpose of ME groups, the group format and members' roles, the leader's role, and the group norms. **Once the goals have been articulated, the trainer should establish group norms** to be followed and **invite group members to identify norms** they wish to follow.

***Initiate the Discussion*:**

The facilitator begins by passing out copies of a moral dilemma, and reads or has a group member read the dilemma to the group. The major points of the dilemma then are summarized through brief group discussion. The trainer should encourage questions from the group that help make the dilemma more clear. The facilitator then should clarify questions, problems, or misconceptions about the dilemma.

Guide the Group Discussion:

The leader begins the moral education discussion by **obtaining initial opinions from each resident and their rationale for their positions. (It is critical to keep this part brief.)** The trainer then **rephrases or paraphrases each participant's rationale**, writes a short summary of initial rationales on newsprint or a chalkboard (the purpose for these procedures is to "stage" each participant so the leader may direct discussion), and **conducts a "differing opinions debate."**

End Discussion:

The facilitator should **summarize debates** for each pair of debaters or for each group, and should **present an argument at one stage higher than the most sophisticated or abstract argument presented**. Again, keep in mind that ***there are no right or wrong answers*. The objective for the ME sequence is to expose individuals to higher order or levels of moral reasoning**.

Practical, Ethical, and Legal Considerations

Aggression Replacement Training has been designed to be culturally and ethnically neutral. As such, **it may be used in any type of environment with homogeneous or heterogenous, culturally diverse clients**. Language barriers may be overcome through translation.

When dealing with violent children and adolescents, the same precautions and ethical standards need to be applied as in any other counseling modality. **While confidentiality must be honored, participants must understand—and the group norms must reflect—that the group and its members are guaranteed their safety and security. Therefore,**

any information that would lead to harmful conditions to group members or others will not be held in confidence. For example, if through the group process the counselor obtains information that a client will commit an act that is in violation of the law, the counselor is obligated to inform the police. If a client threatens harm to himself or herself, the counselor is obligated to refer that information to the appropriate source (in the case of nonreferral, counselors may be held liable for aiding and abetting criminal activities of juvenile delinquents). Finally, as counselors deal with adjudicated youth, or others who are deemed a threat to society by their aggressive or violent nature, they **need to be well-versed in the laws within their jurisdictions that govern their clients**.

Summary

Aggression is a complex, multifaceted, learned, behavioral response. Children and adolescents have become more aggressive, with greater incidence and intensity over the last three decades. **Counselors need to identify and implement appropriate multi-modal treatment interventions to modify the attitudes and behaviors of their aggressive clients.**

The purpose of this lesson is to give the rehabilitation counselor an opportunity to explore the nature of aggression in children and youth, identify the principles of aggressive behavior, and learn, in detail, about one intervention that has been successfully developed, implemented, and evaluated.

For counselors working in the field of rehabilitation, it is imperative to implement professional treatment skills to deal adequately with the growing problem of youth violence. It is equally important to take the time to evaluate new programs and treatment services offered so that we can further develop and enhance the quality of professional tools available.

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Questions Based on this Lesson

13. Which of the following has *not* been found to be characteristic of aggressive youth?

    A. Verbal and physical aggression

    B. Skill deficiency

    C. Immaturity

    D. Outgoingness

14. Which of the following statements about the *modeling* component of Structured Learning Training (SLT) is false?

    A. It demonstrates examples of appropriate ways to use SLT curriculum skills

    B. It consists of live vignettes enacted by the youth in the program

    C. When modeling, one should depict only one skill at a time

    D. The modeled scenario should always depict a positive outcome

15. The following steps:

    Modeled several times; role played one or more times by the trainees; read by the trainee from a chalk board and a skill card; practiced in real-life settings

    are examples of which technique?

    A. Moral Education

    B. Overlearning

    C. Identifying triggers

    D. Identical elements

16. When facilitating a Moral Education discussion, the counselor should:

    A. Ensure that the group is physically and psychologically safe enough for the participants to share ideas and beliefs openly

    B. Allow the group as a whole to select a topic for discussion

    C. Refuse to establish any group norms, because they may inhibit discussion

    D. Provide the "right" answers to the dilemma at the conclusion of the session

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 5

Chronic Fatigue Syndrome: Perspectives on Evaluation and Treatment

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Directions in Rehabilitation Counseling

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Editor's Note

In the past, the etiology of chronic fatigue syndrome was relegated completely to the psychological realm; any physical component was regarded either as purely hypochondriacal or as separate from the real problem. Thus, the concept that the disease may be treated wholly as a medical disorder was often dismissed. In recent years, information has increasingly pointed to the physical disorders that form the foundation for a diagnosis of chronic fatigue.

To qualify for a diagnosis of chronic fatigue syndrome, a person must have persistent or relapsing debilitating fatigue for at least 6 months in the absence of any medical or psychological diagnosis that would explain the clinical picture. It's long been known that episodes of depression can follow viral infections, and this possibility should be considered by any rehabilitation professional working with clients who have been diagnosed with chronic fatigue syndrome. Depression is common in such clients, whether as a major underlying contributor to the clinical state or as a complication of the loss of normal functioning. When depression is concomitant with chronic fatigue syndrome, it can seriously undermine the rehabilitation process, especially when vocational aspects are being addressed. In this context, depression should be regarded as a challenge that the rehabilitation professional must treat separately, but simultaneously, if the process is to be successful.

Rehabilitation professionals often work with clients who have either actually been diagnosed with chronic fatigue syndrome, or who are convinced that their lethargy and lack of motivation have a physical component. Thus, rehabilitation counselors should be familiar with the methods currently used to evaluate and treat this disorder, and also know how to recognize signs and symptoms in clients who may need to be referred to a physician for this diagnosis.

Chronic fatigue syndrome seems to be self-limited, although it can go on for months and even years. It calls for close collaboration between the rehabilitation professional and the client's regular physician. In this lesson, the author reviews the medical basis of chronic fatigue syndrome, including possible infectious and neuroendocrine factors that may contribute to the onset of the disease.

Introduction

This lesson will summarize the condition of chronic fatigue and offer a brief overview of current theories to explain this phenomenon. An argument is made here that treatment planning should consist of a multidisciplinary team approach to this syndrome. The history of chronic fatigue is rich and complex and, in itself, provides interesting insight into the development of the general concept of illness during the rise of industrialization and the emergence of modern medical technology. Because a more thorough treatment of that aspect of the illness is beyond the scope of this lesson, the reader is referred to a number of texts for a more extensive discussion of these issues.[1-4]

The syndromal presentation of chronic fatigue, feverishness, diffuse pains, and other constitutional complaints (often precipitated by an acute infectious illness and aggravated by physical and emotional stressors) has received considerable attention in the lay and medical media over the last decade. What is less frequently emphasized is that similar clinical presentations have been described in medical writings since the early 1700s. In 1750, Sir Richard Manningham wrote of the "febricula," or "little fever," that presented with a variety of constitutional complaints but few objective clinical findings.[1] One of the more lasting appellations for these symptoms, "neurasthenia," was introduced by George Beard in the late nineteenth century and is still used today in the 9th Revision of the World Health Organization's International Classification of Diseases.[2] Beard maintained that the etiology of this syndrome resided in subtle and undetectable alterations in neurochemistry, but the pathophysiology of this clinical entity remains unknown more than a century later.

To facilitate identification of objective characteristics and improve comparability of research studies, a study group convened by the Centers for Disease Control (CDC) in 1988 proposed a working case definition, renaming the illness "chronic fatigue syndrome."[3] Essentially, **clients meeting criteria for the syndrome must have persistent or relapsing debilitating fatigue for at least 6 months in the absence of any medical or psychiatric**

diagnosis that would explain the clinical presentation. Symptom criteria for this syndrome also include **an abrupt onset, low-grade fever, arthralgias** (pains in a joint), **myalgias** (muscular pains), **painful adenopathy** (any disease of the glands, especially of the lymphatic glands), **post-exertional fatigue, neuropsychological complaints, and sleep disturbances** (Table 1). This was the first attempt to bring coherence to a confusing

Table 1

CENTERS FOR DISEASE CONTROL CASE CRITERIA FOR CHRONIC FATIGUE SYNDROME

Major Criteria

(Client must fulfill both major criteria)

- New onset of persistent or relapsing debilitating fatigue or easy fatigability that does not resolve with bedrest and is severe enough to impair average daily activity below 50% of premorbid activity level, lasting for a period of at least 6 months.
- Exclusion of other clinical conditions or medication effects by appropriate history, physical examination, or laboratory tests.

Minor Criteria

*(Client must show 6 or more of the symptom criteria and 2 or more of the physical criteria; **or** 8 or more of the symptom criteria)*

***Symptom criteria**—must have begun at or after onset of the fatigue and must be persistent or recurring*

- Mild fever or chills
- Sore throat
- Painful anterior or posterior cervical or axillary lymph nodes
- Generalized muscle weakness
- Myalgias
- Prolonged post-exertional fatigue
- Headaches
- Migratory arthralgia
- Neuropsychologic complaints (e.g., photophobia, transient scotomata, forgetfulness, irritability, confusion, depression, poor concentration)
- Sleep disturbance
- Main symptom complex having an abrupt onset

***Physical criteria**—must be documented on at least two occasions, at least one month apart*

- Low grade fever (oral temperature 37.6–38.6°C or rectal temperature 37.8–38.8°C)
- Nonexudative pharyngitis (inflammation of the pharynx)
- Palpable anterior or posterior cervical or axillary lymph nodes

array of names and diagnostic criteria that remain in common use to describe this syndrome.

A number of issues regarding this definition deserve comment. A fundamental emphasis was placed on the systematic exclusion of known entities that, early in their course, could mimic this presentation, such as systemic lupus erythematosus (inflammation of the skin marked by crusty patches with raised red edges and depressed centers), rheumatoid arthritis, multiple sclerosis, or certain malignancies. Additionally, the absence of discrete laboratory testing that could be used to bolster confidence in the diagnosis of chronic fatigue syndrome was underscored.

What has remained most confusing about this definition has been a clear delineation of confounding psychiatric illnesses. **At the present time, the ability clearly to differentiate psychiatric illnesses from chronic fatigue syndrome remains elusive.** Most investigators would agree that **formally diagnosable psychiatric illnesses are present in well over half of all cases.**[6–11] **However, the question of whether they are fully explanatory of the clinical presentation, are secondary manifestations of a primary disease process, or are coincident diseases with the fatigue syndrome, modulating its presentation and course, is unanswered.** Indeed, it is precisely because of this latter problem that psychiatrists and rehabilitation professionals should be primary members of treatment and research teams dealing with this client group.

The Role of Psychological Vulnerability in the Development of Chronic Fatigue

Although the etiology of chronic fatigue syndrome is unclear, two principal theories have dominated previous attempts to find a medical basis for this syndrome. **One set of ideas has focused on the behavioral antecedents of the illness, maintaining that the**

disorder represents the psychological aftermath of an acute infectious event in emotionally susceptible individuals. Indeed, as noted above, the prominence of neuropsychiatric symptoms have contributed significantly to the perplexing and frustrating nature of the illness. In 1941, Wood wrote, "...patients should be informed of the nature of their illness and be treated as psychoneurotics; their distaste for this label may prove quite helpful.... The patient must be induced to believe that he is suffering from the effects of emotional disturbance and not from any disease or alteration of visceral function...."[3] **On the other hand, the alternate view has emphasized the importance of the infectious onset, with constitutional symptoms emerging secondary to persistent immune stimulation and/or other lasting changes caused by the initial infectious event.** Inadequate attention has been given to how these two views might interface.

A number of seminal studies served to bolster evidence for the first view. In 1951, in a follow-up study of 65 patients with documented **acute brucella infection,** Spink noted that approximately 20% of these patients proceeded to have prolonged symptoms with no objective evidence of continued, active disease.[12] Although he proposed that these symptoms could be attributed either to continuing infection or to subtle damage to the central nervous system, Spink observed **a high degree of psychological disturbance in this subgroup of patients.** He speculated that "...individuals with functional complaints or personality difficulties may have an exaggeration of these manifestations following acute brucellosis...."[12]

Recently-published studies using structured psychiatric interview techniques have also suggested **the prevalence of psychiatric illness to be higher in those with chronic fatigue syndrome than in the general population and often precede the onset of the fatigue syndrome.**[6-10] **In only one study was the prevalence of psychiatric illness reported to be comparable with that of the general population, and to follow, rather than precede, the development of the chronic fatigue.**[11] However, as emphasized in the

introduction, in the absence of reliable biological measures to identify this syndrome—and given that most established psychiatric diagnostic systems often include fatigue and nonspecific somatic complaints as symptoms of psychiatric disease, **the use of this phenomenologic criteria alone introduces an unavoidable circularity of reasoning when trying to establish a definitive distinction between chronic fatigue and a psychiatric illness.**

Infection and the Development of Chronic Fatigue

Evidence supporting an infectious or persistent **immune dysregulation** as the primary cause of chronic fatigue emerged primarily from a series of reports that began appearing between 1982 and 1985. **These studies reported a spectrum of subtle abnormalities in immunity in these patients, along with atypical profiles of antibody responses to the Epstein-Barr virus and other viral antigens.**[13–15] Such immunologic disturbances, coupled with the observation that **many of these persons developed the syndrome following an episode of acute infectious mononucleosis, led to the specific hypothesis that the illness was a manifestation of chronic Epstein-Barr virus infection. However, subsequent observations have challenged that idea** and suggest that, whereas immune stimulation may be present in these patients, **persistent Epstein-Barr virus infection is almost certainly not a tenable explanation for most cases of the syndrome.** [16–19]

Nevertheless, it is likely that **an acute infectious illness serves as the precipitating event in many, but not all, clients with chronic fatigue syndrome.** Although no clear and convincing evidence has emerged to demonstrate a causal relation between infection with any specific viral agent and the subsequent development of chronic fatigue syndrome, **several viruses continue to receive attention, especially the herpes viruses,** such as **Epstein-Barr virus, herpes simplex viruses, cytomegalovirus, and human herpes virus type 6, and the enteroviruses** (intestinal viruses), **such as coxsackie B virus.**

It should be emphasized that **a role for persistent physical changes following an acute viral infection has also not been excluded as a possible cause of chronic fatigue syndrome.** Indeed, Oldstone and colleagues have provided evidence **in animals** to demonstrate that **viral infections may lead to persistent pathologic changes in cells long after the infection itself has resolved.**[20]

Neuroendocrine Considerations in the Development of Chronic Fatigue

Various forms of neuroendocrine disturbance may also accompany infectious disease in humans and can contribute to the onset of chronic fatigue. For instance, **various acute viral infections activate the hypothalamic-pituitary-adrenal axis;**[21-23] it has been suggested that this is an example of the body acting to contain the infection. In chronic infectious states, such as viral hepatitis or infection with the human immunodeficiency virus (HIV), subtle fluctuations in neuroendocrine function may also occur.[24-28]

With these considerations in mind, our group has recently suggested that **the clinical overlap between chronic fatigue syndrome and a variety of primary psychiatric illnesses may reflect the activation of a shared, final common biological pathway precipitated by a variety of infectious or non-infectious pathophysiologic antecedents.**[29]

First, a review of **the clinical presentation of chronic fatigue syndrome shows considerable overlap with that seen in clients with glucocorticoid** (a hormone of the adrenal cortex that raises the concentration of liver glycogen [the primary carbohydrate storage material in animals that is eventually coverted to glucose] and blood sugar) **deficiency;**[30] **one of the principal symptoms of glucocorticoid deficiency is debilitating fatigue. An abrupt onset precipitated by a stressor, feverishness, arthralgias,**

myalgias, adenopathy, postexertional fatigue, exacerbation of allergic responses, and disturbances in mood and sleep are also characteristic of glucocorticoid insufficiency.[30] These symptoms are often seen in the relatively rare syndrome of partial or subclinical adrenal insufficiency, which may only be detectable by detailed endocrine testing in those who fail to show the symptoms of classical Addison's disease, which include hypotension and abnormal fluid and electrolyte balance.[30] We further suggest that many of the observed immunologic disturbances in clients with chronic fatigue syndrome (e.g., exacerbation of allergic responses) could also reflect a mild glucocorticoid deficiency.

Physical Deconditioning: A Clinical and Methodologic Confound?

Clients with chronic fatigue syndrome commonly report an exacerbation of symptoms after periods of increased physical activity.[5] It is not surprising that the acute infectious illness that often precedes the onset of the fatigue syndrome is associated with extended periods of physical inactivity. Clients may therefore develop exertional fatigue and intolerance of physical activity as a direct consequence of the prolonged periods of acute, disease-associated inactivity. Whether the physical inactivity may account for some, if not all, of the symptoms and biological findings in clients with chronic fatigue syndrome is not clear.

With respect to the neuroendocrine data noted above, it is of interest that the neuroendocrine system can be significantly affected by the level of physical activity or fitness of the individual. Chrousos and colleagues have demonstrated that highly trained runners have significant elevations in basal glucocorticoids compared with sedentary individuals.[31] Furthermore, these investigators have shown that increasing levels of physical conditioning lead to an adaptation of the exercise-stimulated response of the hypothalamic-

pituitary-adrenal axis. Hence, sedentary individuals normally have a more robust stimulation of the pituitary-adrenal response to exercise challenge compared with physically conditioned individuals.[31] The impaired activation of this system that we have reported in those with chronic fatigue syndrome is, therefore, inconsistent with the hypothesis that simple physical deconditioning provides a complete explanation of this syndrome. Furthermore, reports of muscle strength, endurance, and recovery[32]—as well as the results of biochemical,[33] electrophysiologic,[34] and microscopic examinations[35]—have failed to reveal a major disturbance of muscle function in patients with chronic fatigue syndrome. On the other hand, studies of exercise tolerance to aerobic work have shown physiologic measures compatible with prolonged physical inactivity.[36]

It should be emphasized that **there is no rational basis, at the present time, to recommend restriction of the client's level of physical activity as a therapeutic intervention. Indeed, the bulk of the available data would suggest that, if anything, such a treatment approach could be expected to exacerbate the clinical presentation.**

Treatment Trials

Many therapeutic agents have been proposed for the treatment of chronic fatigue syndrome[37] but few formal, double-blind, placebo-controlled trials have been conducted. No specific agent has been clearly shown, in replicated studies, to be a successful treatment for chronic fatigue syndrome. The clinical trials that have been performed have been of great help in bringing some degree of reason to the existing treatment recommendations; however, all are plagued by similar methodologic problems. The establishment of a working case definition for the illness has assisted in the comparability of research efforts; nevertheless, several important trials were conducted before this definition was published, and several others continue to employ definitions idiosyncratic to the investigators' local community. These considerations may not be significant, given that the initial CDC

definition may not describe a homogeneous group of clients distinct from the larger group of persons with chronic fatigue.[18] An additional problem in the interpretation of some studies has been the lack of appropriate behavioral descriptors, such as structured psychiatric interviews or valid and reliable behavioral rating scales. The conspicuous lack of such measures impedes the ability to address the contentious issue of the effect of formal psychiatric illnesses or behavioral symptoms *per se* on treatment outcome. Finally, uniformly agreed upon measures of treatment outcome, whether biological or behavioral, have not yet been established.

ACYCLOVIR:

One of the initial agents to be formally studied for the treatment of chronic fatigue syndrome was **the antiviral agent acyclovir (Zovirax).**[19] This agent, which inhibits the replication of the Epstein-Barr virus in vitro (observable in a test tube) and in vivo (within the living body), was chosen at a time when the specific involvement of Epstein-Barr virus in chronic fatigue syndrome was still in question. Twenty-seven adults were studied in a double-blind, placebo-controlled manner, with a treatment course involving intravenous and oral acyclovir administration. **Similar rates of improvement were seen with both acyclovir and placebo.** Four patients described sustained improvement after discontinuing the treatment; however, in three of the four, the improvement began during the placebo treatment phase.

LEFAC:

In 1989, Kaslow and co-workers[20] reported the results of a double-blind, placebo-controlled crossover study with **LEFAC, a combination of bovine liver extract, folic acid, and cyanocobalamine** (formerly called vitamin B_{12}), a therapy that was popularly advocated and available in the investigators' community. Similar to the acyclovir results,

a substantial placebo effect was noted, whereas **LEFAC demonstrated no effectiveness in the amelioration of overall symptoms compared with placebo**. Two studies, one in the United States[40] and one in Australia,[41] centered on the treatment response to intravenous immunoglobulin G (IV IgG) in persons with chronic fatigue syndrome in a placebo-controlled fashion. The results were conflicting. The Australian group reported significant efficacy of IV IgG in a 3-month trial; on the other hand, the U.S. investigators reported no effect over a 6-month treatment period. The Australian group also noted that those who improved with active treatment showed improvement in a number of immunologic measures. Certain caveats should be kept in mind in interpreting these results, in particular the lack of agreement on the definition of chronic fatigue syndrome between the two studies, as well as conflicting patterns of outcome measures (i.e., in the Australian study, the physicians described overall improvement, whereas the patients themselves did not). The investigators were also cautious, advocating the need for further research before definitive treatment recommendations could be established for this agent.

ESSENTIAL FATTY ACIDS:

In that same year, Behan and colleagues[42] reported the results of a 3-month, double-blind placebo-controlled trial of **essential fatty acids** (i.e., Efamol Marine, a combination of evening primrose oil and fish oil) in 63 persons with chronic fatigue syndrome. Essential fatty acids have been advocated for the treatment of chronic fatigue on the basis of the putative interactions of essential fatty acid metabolism and viral infections. **These investigators reported that, at 3 months, 85% of clients in the active treatment group had shown substantial improvement, and only 17% of placebo-treated subjects had improved. The results have not been examined or confirmed by others.**

MAGNESIUM SULFATE:

Recently, Cox and colleagues[43] reported on a double-blind, placebo-controlled trial of

intramuscular magnesium sulfate. Thirty-two patients were randomly assigned to either placebo or intramuscular magnesium sulfate weekly for 6 weeks. The investigators reported **substantial clinical improvement in the actively treated subjects compared with those receiving placebo.** Although of interest, no clear explanation could be given by the investigators for their findings, nor have they yet been replicated. The possibility that **magnesium administration may produce a nonspecific energizing effect** in normal persons should be excluded before substantive conclusions are drawn from this study.

ANTIDEPRESSANTS:

Antidepressants have been advocated for the treatment of chronic fatigue syndrome. The rationale for their use emerges for several reasons. First, **tricyclic antidepressants have been suggested to have efficacy in the treatment of fibromyalgia, a syndrome closely resembling—and possibly identical with—chronic fatigue.**[44,45] Second, **pain is a significant dimension of disability in this client group, and these agents have also been suggested to be useful in the treatment of chronic pain states.** Finally, as has been mentioned elsewhere in this lesson, **depression, as a syndrome, is a common accompaniment of chronic fatigue. Only one study has examined antidepressant treatment, specifically a single case study of the double-blind, placebo-controlled administration of nortriptyline (Aventyl, Pamelor) in a woman with chronic fatigue.**[46] Interestingly, it was noted that in addition to the expected improvement of her affective symptoms, the patient also reported significant amelioration of her physical symptoms such as fever, lymphadenopathy (disease of the lymph glands), and paresthesias (a morbid or perverted sensation, such as burning, prickling, etc.).

COGNITIVE THERAPY:

A notable nonpharmacologic treatment modality has been an encouraging report of the

successful use of **cognitive behavior therapy in an open trial.**[47] The investigators argued that in some clients with chronic fatigue syndrome, an initial infectious agent may trigger a spiraling cycle in which "...both attributional and cognitive factors fuel avoidant behaviour...." Their treatment program directs specific attention to the treatment of an underlying mood disorder, if it exists, along with specific attention to cognitive distortions emerging from unfounded ideas about the illness, and finally, reducing patterns of behavioral avoidance. **Although promising, those observations await more formal assessment and independent replication.**

A Proposed Program of Clinical Evaluation and Treatment Planning

Chronic fatigue syndrome is a heterogeneous group of illnesses. Nevertheless, certain principles should underlie a general approach to treatment planning. All will not necessarily be relevant in the care of any one client but should serve as an initial point of departure. The domains of interest are summarized in Table 2.

TREATMENT PLANNING:

In general, a collaborative approach to the management of clients with chronic fatigue syndrome is essential. **The two other disciplines that are critical to any treatment program that involves the rehabilitation professional are psychiatry and internal medicine, the latter most commonly concentrating on infectious disease.** Consultative assistance from the specialty areas of rheumatology, neurology, and endocrinology may be necessary during the initial investigative stages. Although individual visits with each of the physicians may occur, presentation of the treatment proposal should ideally involve a meeting of the client with the internist. This format allows for the establishment of a uniform plan of treatment, with a clear outline to the client of the responsibilities and

Table 2

AN APPROACH TO CLINICAL MANAGEMENT FOR CHRONIC FATIGUE SYNDROME

Treatment Planning

- Collaborative approach (psychiatry and internal medicine)
- Joint discussion of treatment plan with client and counselors
- Establishment of a uniform plan of treatment
- Fostering of immediate exchange of relevant data between health professionals
- Ongoing monitoring of treatment progress/problem solving

Laboratory Testing

- NO TEST IS AVAILABLE TO CONFIRM THE DIAGNOSIS
- Minimum laboratory testing
  - Complete blood count with differential white blood count
  - Erythrocyte sedimentation rate
  - Chemistry panel (renal and hepatic function testing)
  - Thyroid function testing
- Viral or other infectious serologic tests are only useful to rule out acute infectious states (e.g., Lyme disease, acute cytomegalovirus infection, acute infectious mononucleosis)
- Other testing should be done, when appropriate, only to rule out established diagnostic entities (e.g., brain imaging, endocrine testing, sleep electroencephalography)

Functional Assessment: Domains of Treatment Outcome

- Fatigue (duration, severity, longitudinal course)
- Psychiatric symptoms/syndromes (affective, cognitive)
- Psychosocial adjustment (employment, family, social/leisure activities)
- Sleep pattern assessment
- Pain management (location, severity, presence of tender points, aggravating and ameliorating factors)

capabilities of the physician(s) and of the client. Furthermore, it fosters the exchange of clinical information and development of a treatment consensus between all health professionals involved. **Such an approach also underscores the lack of current definitive diagnostic testing and the view that chronic fatigue syndrome is, at the present time, a diagnosis of exclusion that does not fall neatly into any discrete clinical domain. Therefore, if novel symptoms emerge during the course of treatment, careful ongoing medical evaluation and collaborative discussion is necessary to avoid premature**

diagnostic closure. Finally, such a format establishes a neutral ground to discuss behavioral symptoms, their meaning for the client, and any possible treatment interventions, whether pharmacotherapeutic or psychotherapeutic.

LABORATORY TESTING AND FUNCTIONAL ASSESSMENT:

Because of the nonspecific nature of many symptoms of this illness and their suggestion of the involvement of multiple organ systems, the list of appropriate laboratory tests may become quite formidable. **Consensus meetings have attempted to provide a minimum battery of screening tests and measures of functional ability during the initial work-up. Substantial clinical information should be obtained to justify further, more expensive or invasive testing.** In the absence of any novel symptoms unrelated to the client's initial complaints, repeat laboratory testing is discouraged at intervals of less than 6 months.

EDUCATION:

A complete understanding of the pathophysiology of chronic fatigue syndrome is not available. Unfortunately, in the absence of reliable information, speculative hypotheses ultimately develop the compelling force of established fact. These unproven hypotheses then foster treatment proposals that may have heuristic merit for future research but may, in their present form, be detrimental to the well-being of the client. Therefore, **education of the client, the treating physicians, and the rehabilitation professional is essential.** At times, it may involve using the sessions to discuss articles in the medical and lay media, differentiating research hypotheses from clinically useful treatments and differentiating both from irrational pseudoscience. It is imperative that the treatment context establish a common ground for discussion of such issues.

PROGNOSIS:

No descriptive studies have examined the clinical course or specific predictors of long-term outcome of clients with chronic fatigue syndrome. Conclusions about the natural history of the illness are therefore drawn largely from anecdotal experience or inferred from older literature of clinical syndromes that appear identical to what we currently refer to as chronic fatigue syndrome. **In most clients, the illness appears to be a self-limited one, with gradual improvement sparked by intermittent periods of symptomatic exacerbation. Recovery may be anticipated in months to years, rather than in days to weeks.** Mortality from chronic fatigue syndrome is assumed to be negligible, but the concurrence of a major depressive episode should introduce concern for the potential risk of suicide.

Conclusion

Chronic fatigue syndrome is most likely a heterogeneous collection of illnesses. It is suggested that a multidisciplinary approach to the clinical management of clients with this illness is essential. Elements of a rational treatment program involve a collaborative planning effort, identification of targets for functional outcome assessment, and education.

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Questions Based on this Lesson

17. A client complaining of which one of the following symptoms might be a candidate for chronic fatigue syndrome?

    A. High-grade fever

    B. Persistent muscular aches

    C. Gradual onset

    D. Energy after a long rest

18. Which of the following statements about chronic fatigue syndrome is correct?

    A. Viral infections may contribute to the condition by leading to persistent changes in cellular function long after the initial infection itself has resolved

    B. It has been conclusively shown that persistent Epstein-Barr virus infection causes chronic fatigue syndrome

    C. Contact between the rehabilitation counselor and the client's own physician should be kept to a minimum to prevent transference and countertransference problems

    D. Persistent physical changes after an acute viral infection have been ruled out as possible causes of chronic fatigue syndrome

19. Clients with chronic fatigue syndrome:

    A. Should never take antidepressants, because they can exacerbate the condition even when evidence of depression is also present

    B. Should always significantly restrict their physical activity until complete improvement occurs

    C. Should try to ignore the depression they feel, because it always has a completely physical basis

    D. Should undergo tests to exclude any other clinical conditions or medication effects

20. In the treatment of clients with chronic fatigue syndrome:

    A. The antiviral agent acyclovir has proved spectacularly successful

    B. All clients should receive a trial with LEFAC, a combination of bovine liver extract, folic acid, and cyanocobalamine

    C. Intramuscular magnesium sulfate has been reported by Cox and colleauges to produce substantial clinical improvement

    D. Essential fatty acids should be the primary choice of treatment because initial results of the acids' combined effectiveness have been examined and confirmed by numerous researchers

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 6

Counseling Dual Diagnosis Clients: Issues and Interventions

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Directions in Rehabilitation Counseling

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Editor's Note

As much as 80% of substance abuse populations concommitantly suffer from one or more mental disorders. Moreover, it is believed that 40% of clients presenting for treatment of alcoholism suffer with an affective disorder, and 30%–40% of those with affective disorders simultaneously abuse alcohol or other depressant drugs. Rehabilitation with the dually diagnosed is especially complex because of the intricacy of any dual diagnosis. The counselor needs to take care in assessing *individual* differences in substance use patterns, mental status, and perceived reasons for using substances. To complicate matters further, coexisting psychological disorders and substance abuse often affect the course of each other; thus, traditional psychological and chemical dependence approaches may not satisfy treatment needs of the dually diagnosed.

In this lesson, Dr. Chiauzzi discusses this extremely complex topic—characteristics of the dual diagnosis client and appropriate treatment approaches. The author outlines the relationships between psychopathologic and addictive disorders, treatment models, psychotherapy issues, stages of psychotherapy, and relapse prevention. It is important that counselors fully understand the dual diagnosis problem so that they can confront the unique counseling difficulties associated with dual diagnosis clients, assess the proper treatment stage, and appropriately implement the author's recommendations at any given time in the recovery process.

Rehabilitation with dual diagnosis clients can be a frustrating process for both counselor and client; a setback in treating the substance addiction may precipitate a setback in treating the psychological disorder. Therefore, the counselor must be able to discuss objectively with the client the intricate nature of the dual diagnosis problem as well as specific treatment goals. Proper understanding of the dual diagnosis problem by both counselor and client can reduce the impact of minor setbacks, eliminate unrealistic goals, and foster a productive counselor-client team relationship in the recovery process.

The Dual Diagnosis Problem: Introduction

As the sophistication of addictions treatment has grown, ignoring the treatment complications posed by those with both addictive and mental disorders has become impossible. Statistical estimates are quite dramatic, as there exists major overlap between mentally disordered and addicted populations. **The dually diagnosed comprise as much as 80% of substance abuse populations and 30%–50% of psychiatric populations.**[1] Weiss and Rosenberg[2] found that **40% of clients presenting for treatment of alcoholism were suffering from an affective disorder**, and **30%–40% of those presenting with affective disorders were abusing alcohol or other depressant drugs**. Other studies indicate that 10%–30% of alcoholics have panic disorder, and about 20% of those with anxiety disorders abuse alcohol.[3] When entering treatment, about **two thirds of alcoholics have symptoms that resemble those seen in anxiety disorders.**[4] Over the course of a lifetime, **between 10% and 65% of schizophrenics experience substance abuse disorders.**[5] The prevalence of schizophrenia is about four times greater in alcoholics than in nonalcoholics.[6] **Cocaine addicts have a high prevalence of concurrent depression, bipolar disorder, and attention deficit disorder,**[7] and **the lifetime risk of major depression among opiate addicts may be as high as 75%.**[8]

One survey of persons admitted to an inpatient substance abuse program found that 57% had personality disorders.[9] Evidence from that study suggested **those clients used more illegal drugs, were less satisfied with their lives, and were more impulsive than were substance abusers without personality disorders**. Antisocial personality disorder is most frequently diagnosed: alcoholic men range up to 50% and alcoholic women range up to 20%.[10] This is significantly greater than the 4% of males and 0.8% of females diagnosed as such in the general population.[6] The second most frequent personality disorder diagnosed was the borderline type, in about 10%–20% of cases.[11] In general, the

latter group tends to manifest poorer impulse control and reality testing, more depression, and greater antisocial behavior than those without borderline pathology.

The combination of mental and addictive disorders is associated with significant impairments and poorer treatment outcome. The best predictor of relapse in addiction is psychiatric severity; i.e., addicted clients with severe psychopathologic disorders have difficulty benefiting from inpatient and outpatient addiction treatments.[12] Conversely, those with low psychological severity can benefit from virtually any type of addiction treatment.

What difficulties do dually diagnosed clients present in counseling? Cross-sectional studies have shown that they are **more likely to be disruptive, aggressive, and verbally hostile, and experience difficulty managing the practical aspects of their lives.**[13] Also, **dual diagnosis clients lack the coping skills necessary to use treatment, are treatment noncompliant, are prone to residential instability, and are more likely to become institutionalized in hospitals and jails.**

Relationships Between Psychopathologic and Addictive Disorders

Meyer[14] suggests several ways in which psychopathology and addiction may coexist: (1) **Psychological disorders may be risk factors for the development of addiction**; (2) **psychopathology may alter the course of addiction**; (3) **substance use may alter the course of psychological problems**; (4) **psychopathology may develop as a result of addiction and persist after the substance abuse is arrested**; and (5) **psychopathology and addiction may originate from a common vulnerability**. Clients with these combinations may present in similar ways, but for very different reasons. **Interpreting the**

mental disorder as more critical than the addiction (or vice-versa) may be misleading and produce poor outcomes. Instead, the counselor carefully needs to assess *individual* differences in substance use patterns, mental status, and perceived reasons for using substances.

The relationships between psychopathology and addiction become even more complex when psychological disorders are considered individually, because the linkages may vary among disorders. Research indicates **a prevalence of coexisting affective disorders and substance abuse, and that these disorders affect the course of each other**. Furthermore, affective disorders increase the risk of substance abuse, and these disorders share common vulnerabilities.[15] Depression may reduce treatment compliance, and alcohol use may reduce the efficacy of depression treatment. Alcoholics with depression generally began drinking at an earlier age and progress to problem drinking sooner than alcoholics without additional psychopathology. Familial affective disorders may also serve as risk factors for substance abuse.

Bukstein and colleagues[15] also suggest varying relationships between anxiety and substance abuse. They found **high rates of agoraphobia, phobias, and panic disorders among substance abusers, with the overlap resulting from**: (1) **Withdrawal symptoms** of alcohol, opiates, or barbiturates; (2) the need for **tension reduction**; or (3) an **increased risk of anxiety disorders in relatives of alcoholics**. In addition, a minority of the dually diagnosed (less than 25%) develop an anxiety disorder *after* a period of substance abuse.[11]

Finally, **schizophrenics are thought to use substances to reduce such symptoms as poverty of speech, affective flattening, anhedonia, asociality, attentional impairment, or dysphoria**.[16] In reality, **substance use (particularly the use of alcohol) by schizophrenics can compromise already-impaired cognitive functions such as memory**. It can also affect the course of schizophrenia, because stimulant use can precipitate an earlier onset of schizophrenia in high-risk persons; alcohol use has been associated with higher

vulnerability to relapses among schizophrenics.[5] Also, relapses are often caused by discontinuation of psychotropics.

Organizational Impediments to Effective Treatment

Because of the often-confusing clinical picture presented by the dually diagnosed, **traditional psychological and chemical dependence approaches and assumptions may not meet treatment needs.** In fact, many impediments within both the mental health and chemical dependence systems may actually preclude effective treatment.[17] Within the mental health system, substance dependence has been considered secondary to the psychopathologic disorder. However, as stated earlier, there may be *several* relationships between substance use and psychopathologic symptoms.

Other assumptions surrounding mental health treatment of the dually diagnosed may also impede clinical progress. **Identification of underlying conflicts is a common goal of psychodynamic psychotherapy, but intervening in this manner during early phases of recovery may be counterproductive and actually increase the probability of relapse.**[18] That is especially true of exploration of past trauma, such as physical or sexual abuse. In addition, there has been a **long-standing strain between the mental health professions and 12-step groups,** because professionals may regard such groups as scientifically untested or religiously biased. However, in recent years there has been a thaw, which may be attributed in part to the fact that many Alcoholics Anonymous (AA) members are also being treated for psychological disorders and recognize the benefits of combining self-help with psychoactive medication and/or psychotherapy.

Impediments also exist within the chemical dependence system. Many recovery counselors base their treatment on their own recoveries; i.e., self-help involvement, and **may not receive training in psychopathologic diagnosis.** Within self-help groups, there

has been a **bias against the use of psychoactive medications** because they are thought to represent substitutes for drugs of choice. In addition, many of those in recovery feel that "you have to have been there." Such thinking results in a minimization of potential benefits from professional treatment. Finally, as in the general population, there is much **fear and ignorance of mental disorders**. Many people equate a diagnosis of mental disorder with being "crazy." Again, with increasing recognition of dual diagnosis, greater training and understanding have been devoted to the diversity of those who are addicted.

Treatment Models

Clinicians and researchers have recognized the deficits mentioned above and have begun to address the need for comprehensive models of treatment. Several that balance psychological and addiction awareness will be discussed: (1) **Integrated treatment approaches**; (2) **the self-medication model**; and (3) **the biopsychosocial model**. Each model offers a different conceptual framework for combining addiction and psychological treatment, but all recognize **abstinence as a prerequisite for a positive outcome**.

INTEGRATED TREATMENT:

The integrated treatment model seeks to identify commonalities between traditional recovery and psychological interventions, relying on a disease-oriented approach.[19-21] These commonalities can include heritability, etiology, chronicity, incurability, potential for relapse, and denial.[21] **The approach de-emphasizes traditional techniques such as confrontation and seeks to "engage" the client in a long-term recovery outlook. Each disorder is considered primary**, regardless of onset and severity. A comprehensive use of this model would include components such as **crisis management, medication management, psychosocial rehabilitation, relapse prevention, family support and education, case management, and 12-step programming**. This model is

useful in combining current treatment approaches in a pragmatic and comprehensive manner, but relies on traditional biological assumptions about the addictive process.

SELF-MEDICATION:

The self-medication model is based upon the psychodynamic notion that certain substances are chosen preferentially for their ability to ameliorate specific negative affects such as rage, loneliness, depression, boredom, or emptiness.[22] In the perception of the addicted person, the use of substances "corrects" the feeling of helplessness brought about by an inability to modulate affect. Poor interpersonal relations are associated with these limitations, resulting in the substitution of the chemical for human object relationships. The chemical object has an advantage over a real relationship—it is always available. Hence, many addicted people make comments such as, "Cocaine is my wife," or, "I'm married to the bottle." These ego deficits lead to inadequate "self-care" functions, which is related to low self-esteem and poor anticipation of danger. **Treatment involves exploration of life situations to help clients improve recognition and tolerance of negative affects, develop self-protective behavior, cope with the sense of powerlessness associated with addiction, and gain an understanding of the object meanings of addiction**. This model provides insight into the dynamics of substance use, because relapse research has established that mismanaged emotions are primary precipitants to relapse and that guilt can exacerbate relapse.[23] **With dual diagnosis clients, the self-medication model is useful in connecting the use of the substance to underlying symptoms and in identifying the nature of the relationship between the substance and psychological disorder**.

BIOPSYCHOSOCIAL MODEL:

The use of the term "biopsychosocial" is common within addiction and psychological treatment, but it typically refers to the combination of interventions within disease-model

treatment programs. The **biopsychosocial model**, as stated here, has been proposed by several authors[24-26] and **stresses the importance of *individualized* assessment of biological, psychological, and social risk factors. Each addicted person experiences different combinations of these risk factors**; i.e., some people possess high biological loading (e.g., severe physical dependence, family history), whereas others possess high psychological loading (e.g., psychopathologic symptoms, positive expectancies for substance use) or social loading (e.g., family dysfunction, unemployment).[24] This includes the possibility that an addicted person may have *no* biological loading. **The biopsychosocial approach makes no assumptions about the etiology, progression, or maintenance of addiction. Therefore, the model allows for greater flexibility. This model recognizes the physiologic effects of substances but also places importance upon addicts' perceptions and the social milieu of the drug experience**. Use of this model with the dually diagnosed can also illuminate biological, psychological, and social vulnerabilities to relapse. As a result, it encourages multidisciplinary intervention, including psychiatric treatment, cognitive-behavioral techniques, and family therapy. The client is taught to balance awareness of and intervention with risk factors rather than to explain difficulties in terms of a single (e.g., biological or disease) process.

Psychotherapy Issues in Dual Diagnosis Treatment

There are five issues that are often overlooked in the psychotherapy of the dually diagnosed: (1) **The nature of denial**; (2) **motivational enhancement**; (3) **protracted withdrawal effects on assessment**; (4) **nicotine addiction and recovery**; and (5) **self-help groups**.

The first issue concerns **denial, which is typically associated with addiction but is also evident in psychopathologic and even physical disorders. The dual diagnosis**

client who has been treated within the addiction treatment system may be accepting of an addiction diagnosis but not a psychological diagnosis. The opposite may be true for the dual diagnosis client treated within the mental health system. The former may resist psychological terminology because of expectations that others will view him or her as "crazy." The latter may seek to explore underlying emotional themes without necessarily abstaining from alcohol or drugs. **Substance use can interfere with remission of psychopathologic symptoms, effectiveness of psychtropics, or ability to engage in psychotherapy. Lack of compliance with psychiatric treatment or psychotherapy can interfere with recovery from addiction**; e.g., anxiety or depression may increase the desire to use alcohol. The counselor's goal is to educate the client about the "parallel" nature of dual disorders,[21] which may be enhanced by reviewing past relapses or past symptoms during abstinence periods. In effect, **ignoring either disorder can be construed as a relapse.**

The second issue concerns **motivation**, which may be limited because of the frustrating nature of dual disorders and past relapses with either disorder. Many dual diagnosis clients are ambivalent, indecisive, and conflicted, which may result in a self-fulfilling prophesy of failure. Motivation is usually considered a trait, but it is actually a function of the interaction of the client and therapist.[27] The technique known as "**motivational interviewing**" is based upon five general principles: (1) **Expressing empathy for ambivalence**, which is normal in recovery; (2) **developing discrepancy between present behavior and desired behavior**; (3) **avoiding argumentation**, which can solidify client resistance; (4) "rolling" with resistance by **inviting the client to consider new perspectives**; and (5) **supporting self-efficacy by believing in change and placing the responsibility for change upon the client. Adopting a collaborative problem-solving approach rather than a confrontational, subjective stance** will likely produce more meaningful change. One method that I have found useful is reviewing computerized psychometric test results (e.g., Minnesota Multiphasic Personality Inventory [MMPI], Millon Clinical Multiaxial Inventory

[MCMI]), neuropsychological screening measures, and/or addiction inventories with clients. These objective measures provide personalized feedback, and clients can be encouraged to reflect upon *their* interpretations of the results.

The third issue, the **effect of protracted withdrawal on assessment**, is often confusing, because **the psychological symptoms of alcohol and drug withdrawal can overlap greatly with depressive, anxiety, and even psychotic disorders**. Approximately 75% of alcoholics evidence varying degrees of neuropsychological dysfunction.[28] In addition to abstract reasoning problems, poor problem solving, impaired short-term memory, and visual-spatial deficits, many recovering people experience insomnia, fatigue, distractibility, mood liability, and irritability. The persistence of these symptoms is particularly troubling to those in recovery, because a high proportion of those in their first 6 months of abstinence experience poor memory, thought blocking, trouble concentrating, or unpleasant thoughts.[29] There tends to be a natural course of recovery of cognitive functions with alcoholism. As long-term memory functions (e.g., vocabulary) are generally unimpaired, verbal learning improves after 2–3 weeks of abstinence, and the ability to retain new information improves after 1–2 months of abstinence.[30] Abstract reasoning deficits may last even longer, sometimes for years.

Several strategies may be used to clarify psychological assessment early in the recovery process. First, **because verbal intelligence functioning** (e.g., vocabulary) **is not typically impaired, it can be used as a baseline by which other cognitive test results can be interpreted**. For instance, if vocabulary scores are above average and short-term memory functioning is below average, the impairment may stem from the substance abuse. Second, **assessment should include a review of historical indicators**, such as family history of mental disorders, the etiology of psychological symptoms prior to the initiation of addictive behavior, past experience with withdrawal, continuation of symptoms during past abstinent periods, and past responses to psychotropics. Third, **repeated assessment**

through the use of questionnaires such as the Beck Depression Inventory should indicate a gradual decrease of symptoms. Depression is so common in early recovery that clinicians recommend that antidepressant medication not be introduced unless the client has already achieved 4 weeks of abstinence.[31] Finally, when using psychometric test results, certain clinical scales such as depression may be elevated because of substance use. Rather than dismissing the test as not representative of actual personality functioning, it is useful to review the results with the client. This exercise can allow the client an opportunity to comment on whether elevations are attributable to personality characteristics or substance abuse—or some combination of the two. The counselor thereby gains information about insight, denial, and substance effects.

The fourth issue, nicotine addiction, is often underestimated because it is not included in discussions of substance abuse. It is noteworthy that 50%–90% of mentally disordered and addicted clients smoke, whereas the rate within the general population is about 30%.[32,33] There are little data regarding nicotine addiction among the dually diagnosed, but it seems safe to say that their smoking is significantly greater than among those in the general population. Nicotine can produce psychological changes: low doses can produce stimulation and higher doses can lead to a depressant effect,[34] so smoking may become a form of self-medication. Schizophrenics may use nicotine to increase concentration or reduce tension—and may actually require higher levels of psychotropic medication while actively smoking.[35] The prevalence of smoking among anxiety-disordered and depressive clients is high, and smoking cessation may exacerbate such symptoms.[36] In fact, anecdotal reports indicate the potential for an increase in suicidal thinking among depressives who have recently stopped smoking.

The fifth issue, self-help groups, becomes critical because attendance at AA or Narcotics Anonymous (NA) is routinely included in the treatment plans of the dually diagnosed. Involvement in 12-step programs has definite advantages: (1) Such programs

provide **a ready-made support group** that can assist in *both* psychological and addiction treatment goals; (2) **the hopeful messages and testimonials of group members can have an "antidepressant" effect**; (3) **unambiguous rules and guidelines may help guide behavior**; (4) clients have an opportunity to **practice development of healthy relationships**; (5) clients can rely on a **broader support system beyond the counselor**; and (6) **attendance at groups may prevent relapse with both psychological and addiction problems**.

However, **attendance at groups is not so simple for those who lack social skills, feel trapped in a group setting, or who have difficulty disclosing personal information**. The depressive may be told that he or she is "sitting on the pity pot." The person with post-traumatic stress disorder (PTSD) may experience anxiety about past events when reminded by others' "drunkalogues." Because of their diverse needs, **dual diagnosis clients require a more flexible approach to self-help groups than is typically offered.**[37] The counselor is therefore encouraged to: (1) **Describe the format of self-help meetings**, because they are often confusing to newcomers; (2) **provide relevant literature** (e.g., the "Big Book") that explains the philosophy of the groups; (3) **employ social skills training such as conversational skills**; (4) **discuss the myths of self-help groups** (e.g., that they engage in "brainwashing"); and (5) **encourage the client to experiment with different types of meetings** until he or she finds a comfortable combination.

Stages of Psychotherapy with Dual Diagnosis Clients

Because of their complicated presentation, **dual diagnosis clients are best treated in phases**. DiClemente,[38] drawing upon the work of James Prochaska, breaks down the recovery from addiction, psychological states, and psychopathologic disorders into five phases: (1) **Precontemplation**, which is characterized by the "four R's" (reluctance,

rebellion, resignation, and rationalization); (2) **contemplation**, in which the client understands the need for change but is ambivalent; (3) **determination**, in which the client has made a decision to change; (4) **action**, in which the client implements a plan and learns appropriate skills; and (5) **maintenance**, which requires relapse prevention skills. Most treatment of the dually diagnosed expends maximal effort during the action phase, but many people "recycle," perhaps by reverting to unhealthy behavior and even returning to a precontemplative stance. Although the action phase takes 3–6 months to complete, the maintenance phase takes a lifetime. Thus, **the bulk of clinical activity should address "staying stopped" rather than stopping addictive or psychological symptoms**.

What are the primary clinical interventions during each of these phases? **During the precontemplation phase, the client is not conceptualizing addictive or psychological symptoms, so the counselor should seek to increase cognitive dissonance by providing information and feedback**—the more objective the better. Subjective impressions will likely meet with resistance, so **formal assessments** (psychological testing, laboratory results, information about dual diagnosis problems) **may yield better results**. **Prescribing interventions at this stage** (e.g., attending AA) **will probably be unsuccessful** because the client has not yet determined that there is a problem that requires intervention.

Even though the client may then enter **the contemplation phase (agreeing that there is a problem), there may still be much ambivalence about change**. The counselor's goal should be to **highlight the negative aspects of the addiction, enhance the positive aspects of recovery, remove barriers to change** (e.g., facilitating an understanding of the withdrawal process, and **increase self-efficacy through contact with similar people** who have successfully made changes. Active intervention at this stage may prove too daunting to an ambivalent person.

The client who has worked through his or her ambivalence will then enter the determination phase, which calls for a statement of commitment to change. The task of the counselor at this point involves exploration and specification of a plan; e.g., a treatment contract. Typical provisions would be: (1) Agreement on a method of detoxification; (2) specification of amount and type of educational, psychotherapeutic, rehabilitative, and self-help interventions; (3) inclusion of family members in educational and therapeutic activities; (4) if necessary, random drug/alcohol screening; (5) agreement to take psychotropic medications as prescribed; and (6) avoidance of substitute addictive substances or behaviors.

Once intervention begins, the action phase is underway. It is important to inform the client that this phase is only a beginning and that the notion of "cure" should be dismissed. Many dual diagnosis clients respond favorably to early interventions and then assume that their active steps can be discontinued. Such impatience can easily induce relapse with either or both of the disorders, so the counselor should emphasize that the recovery process requires an extended period of intervention and monitoring to determine if enduring changes have been established. Other clients expect "overnight" revelations that will provide automatic relief. The concept of recovery as a lifestyle change rather than as a reduction of symptoms should be stressed.

Finally, ongoing change will require maintenance strategies in the form of relapse prevention. As stated earlier, severe psychopathologic disorders are the most accurate predictors of relapse, so clients should be educated about the potential for relapse. Identification of high-risk situations, unresolved emotions (e.g., resentment, anxiety, depression), and negative personality patterns will help the client monitor relapse risk. In many recovering dual diagnosis clients, it may take at least a year to establish abstinence firmly. In early phases, clients may be concerned about coping with drug-using friends, a resurgence of craving, or maintaining their recovery plan. In later phases

the primary questions may change to self-actualization, identity, intimacy, long-range goals, review of past trauma, or gaining insight into family and/or relationship issues. Undertaking exploration of these questions too early may actually increase the risk of relapse, so a conservative approach is recommended. This is especially seen with sexual and physical abuse, because current public education may increase the client's desire to resolve residual psychological pain. The counselor can partially satisfy this need by focusing on behavioral manifestations of the abuse while reserving exploration of intense emotional issues for later in the recovery process.

Relapse Prevention with Specific Psychopathologic Disorders

DEPRESSION:

The primary concern with depressed persons who abuse substances (particularly alcohol) is the risk of suicide. The Group for the Advancement of Psychiatry[7] cites three significant findings: (1) The lifetime risk of suicide among alcoholics is about 15%; (2) alcohol abuse is a factor in about 25%–50% of suicides; and (3) alcohol is second only to affective disorders as a risk factor for suicide in the general population. Suicide assessment is crucial for all depressed substance abusers, even those who deny such tendencies while abstinent. Substance use can lower behavioral controls in those who are prone to depression, so relapse prevention should include identification of high-risk situations for suicidal behavior.

Relapse prevention should be a routine approach during the recovery process for the depressed substance abuser, because time erodes treatment gains. Relapse rates among depressed clients are about 20% by 6 months, 40% by 12 months, and 50% by 24 months.[39] Several predictors of depression relapse have been identified: (1) Number of previous episodes; (2) frequency of major life events; and (3) a high level of ex-

pressed negative emotion by family members.[40] **Development of high-quality social support, awareness of high-risk depressive situations, and identification of pleasant events to counter negative life events are important treatment components with these clients.**

ANXIETY DISORDERS:

Anxiety disorders are chronic conditions that result in periodic exacerbations and remissions.[41] Pharmacologic treatments (e.g., the use of tricyclic antidepressants such as imipramine [Tofranil] and newer agents like fluoxetine [Prozac] and sertraline [Zoloft]) result in a relapse rate of approximately 35%–40%, whereas about 25%–40% of clients fail to show a significant treatment response with behavioral (e.g., cognitive-behavioral) therapy.[42] **Even among those who do benefit from treatment, many continue to experience anticipatory anxiety and avoidance behavior**. As a result, **they should be prepared to view outcome with anxiety somewhat differently than outcome with addiction**; i.e., complete abstinence may not be possible. The **inclusion of the spouse** in the treatment of anxiety disorders **should be considered as a means of improving outcome**, because it may reduce dropout and facilitate practice of anxiety-reduction skills, such as exposure to arousing situations and relaxation techniques.[42]

Another important consideration with anxiety-disordered substance abusers involves the **addictive nature of minor tranquilizers**. Rehabilitation professionals should consult with the client's prescribing physician to ensure every effort is made to consider nonaddictive medications, because addiction-prone persons have high potential for abusing drugs such as diazepam (Valium), chlordiazepoxide (Librium), and alprazolam (Xanax). Psychological approaches should be fully explored, even if anxious clients fixate on a medication solution. Barlow's[41] exposure-based behavioral treatment or the cognitive therapy approach of Beck and Emery[43] offer viable alternatives.

SCHIZOPHRENIA:

Because of its debilitation, the clinician might easily ignore substance abuse problems associated with schizophrenia. Deinstitutionalization has left many schizophrenics to fend for themselves, resulting in involvement for many in substance abuse. Schizophrenic clients lack many of the qualities that lead to a favorable treatment outcome; e.g., cognitive skills, social support, insight, stimulating activities, stable living arrangements, motivation, and employment. They also **lack the communication skills** to respond to social pressure, do not seek help to cope with craving, or cannot explain underlying emotions that relate to substance use. As a result, **treatment must be more flexible, comprehensive, multidimensional, and long-term than with other dual diagnosis conditions**. For instance, **schizophrenics may have difficulty agreeing to abstinence** as a condition of treatment and may need a period of "engagement" for months before they submit to intervention.[5] Some traditional recovery philosophies such as confrontation and the absolute prohibition against *all* medications do not fit this group, because such beliefs may create strong and unmanageable affect. **The focus instead is placed upon persuasion, support, education, skill building, and development of a social network**. Twelve-step involvement, although challenging for this population, should not be ruled out. Counselors should openly discuss differences between psychological and self-help philosophies, but they should frame these groups as support systems for both the addiction and schizophrenia.

PERSONALITY DISORDERS:

Untreated personality disorders can contribute to relapse, but because the focus of current addiction treatment is placed upon the ill-conceived notion of "addictive personality,"[7] little attention is given to these disorders. **A careful diagnosis of personality disorders can yield a rich source of data regarding relapse potential. In addition, the *way* people relapse can conform to their personality style**. Antisocial personalities may

reject feedback; paranoid personalities may resist self-disclosure; dependent personalities may rely on others to maintain their recovery plans; passive-aggressive personalities may harbor resentments; avoidant personalities may feel threatened in self-help groups; and compulsive personalities may seek excessive control and predictability in the recovery process. It is therefore critical to evaluate the manner in which the personality style interacts with relapse risk factors to foster a return to psychopathologic symptoms or substance use.

Summary

The dual diagnosis problem is both prevalent and complex. The dually diagnosed comprise as great as 80% of substance abuse populations and 30%–50% of psychiatric populations. These figures represent a challenge for any rehabilitation counselor working with clients who are abusing a substance and/or experiencing a psychological disorder. But the real challenge with dual diagnosis clients is understanding the combinations by which psychopathology and addiction may coexist. Not only can clients with the combinations outlined in this lesson present in similar ways, but they can do so for different reasons.

This lesson has outlined relationships that constitute dual diagnosis problems, treatment models, psychotherapeutic issues, stages of psychotherapy, and relapse prevention in an effort to familiarize rehabilitation counselors with the dual diagnosis problem and to make concrete recommendations as dual diagnosis clients progress through various stages of treatment. Counseling strategies tend to vary depending upon the combination of a dual diagnosis and the severity of addiction and pathology. Therefore, it is imperative that rehabilitation professionals understand all aspects of the dual diagnosis problem—not only to implement more effectively the appropriate treatment goals, but also to explain clearly to a particular client the rehabilitation process as it relates to his or her dual diagnosis. This way, the rehabilitation counselor and the client will be empowered to work as a team in the recovery process and subsequent relapse prevention.

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Questions Based on this Lesson

21. According to the author, the best predictor of relapse in addiction is:

    A. Employment status

    B. Tolerance to psychoactive medications

    C. Psychiatric severity

    D. Level of education

22. Which of the following statements is correct?

    A. Dual diagnosis clients tend to be treatment noncompliant

    B. Traditional psychological and chemical dependence approaches and assumptions always meet the treatment needs of the dually diagnosed

    C. In the treatment of the dually diagnosed, intervening in the early phases of recovery with psychodynamic psychotherapy is never counterproductive

    D. The addictive nature of minor tranquilizers is the most important consideration with schizophrenic substance abusers

23. The biopsychosocial treatment model:

    A. Discourages multidisciplinary intervention

    B. Emphasizes improving recognition and tolerance of negative affects

    C. Stresses the importance of individualized assessment of biological, psychological, and social risk factors

    D. Makes assumptions about the etiology, progression, or maintenance of addiction

24. Risk of suicide is the primary concern for which type of dually diagnosed clients?

    A. Schizophrenics

    B. Those who are clinically depressed

    C. Anxiety-disordered persons

    D. Those suffering with personality disorders

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 7

An Update on Computer Applications in Rehabilitation Counseling

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Directions in Rehabilitation Counseling

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Editor's Note

The technological explosion of the 1980s generated benefits unparalleled in any previous decade. We have changed the way we eat (microwaves), work (personal computers and facsimile machines), communicate with others (answering machines, call waiting, modems), entertain ourselves (VCRs, CD players, cable television, interactive telephone services) and even obtain the money to purchase these products (ATMs). The almost unlimited development of new technology has created not only new demands, but also new industries and new jobs to fill these demands.

The rehabilitation profession has been affected by this growth in three main ways: in the ever-increasing number and types of jobs of which rehabilitation counselors must be aware in order to provide adequate placement services to their clients; in the continuing refinement of assistive technology that seeks to minimize the limitations of those with physical disabilities; and in the way rehabilitation professionals conduct their day-to-day business.

The authors of this lesson provide a thorough overview of the computer technology that is currently available to rehabilitation professionals in all three of these areas. Their discussion is divided into the categories of "Counselor-Centered Applications," which are mainly utilized by the counselor in data gathering, assessment, and record keeping; and "Client-Centered Applications," which concentrate on the assistive technology for training, skill development, and minimizing physical limitations.

Introduction

Over the last decade, our society has witnessed some incredible advances in technology. Most notable are the advances made in computers and their involvement in almost every aspect of our lives. Rarely do we go through an entire day without some direct or indirect interaction with a computer, whether it be when we drive a car in which performance is monitored and stored on a computer chip, or when our groceries are being checked out at the local convenience store. Many people interact directly with computers through computer programming, word processing, and other occupations created or enhanced by the advent of and advances in computer technology.

Until recently, the cost and size of computers prohibited their use in everyday operations. Because of their enormous size, computers often had to be housed in large rooms with environmentally controlled atmospheres to ensure optimal operating conditions for their delicate components. However, **the last decade has seen rapid developments in integrated circuit technology, enabling computer manufacturers to condense the central processing unit (CPU) to an inexpensive silicon chip smaller than a postage stamp.**[1] This advancement has led to the development of small, inexpensive, and powerful micro- and mini-computers able to perform complex operations that formerly required large and expensive mainframe computers. These smaller computers have become increasingly versatile and "user friendly," allowing a wider range of people to take advantage of the new technology. **Unlike their predecessors, small computers do not require "special attendants" or optimal environmental conditions for proper operation. Also, improved software for micro- and mini-computers has meant that users no longer need specialized training in computer programming to perform common operations.**

It has been noted that our economy is changing from a manufacturing-based one to an information- and service-based one.[2] It follows, then, that the computer is being used increasingly to store and process large amounts of information with speed and efficiency never before possible. As the use of computers becomes more widespread in our society, **the types of jobs available are rapidly changing and, consequently, so is the training necessary to prepare for those jobs. Also, the computer has modified the essential functions of numerous existing jobs, with the result that many workers must now have some degree of computer literacy.**

The field of rehabilitation has benefited in a variety of ways from these technological advancements. A review of the literature indicates that **computers are active in almost every phase of the rehabilitation process,** including **rehabilitation counseling, case management, vocational evaluation, work adjustment, and job placement.**[4-7] Computers allow counselors to perform more efficiently and effectively by providing immediate access to current, relevant information on specific problems presented by clients. In addition, computers and computer technology play a major role in electronic assistive devices, augmentative communication devices, environmental controls, and robotic technologies.[8] These devices are enhancing the quality of life for people with disabilities—in both their home and work environments. The benefits from this type of technology were acknowledged by the federal government in the 1986 Amendments to the Rehabilitation Act.[8] These regulations require that rehabilitation engineers/technologists be included on teams that deliver federally funded rehabilitation services. All rehabilitation professionals have an increasing responsibility to become knowledgeable about computers and related technologies and to keep their knowledge current so that they can apply it for more effective and efficient delivery of services to their clients.

Trends

Adaptive technology for people with disabilities and software programs for rehabilitation counselors undoubtedly will increase and improve over time. Congress

recently amended the Vocational Rehabilitation Act of 1973 so that **the facilities of computer manufacturers who sell equipment to the government are required to be accessible to people with disabilities**. Furthermore, the federal government is prohibited from purchasing computer equipment that cannot be adapted for use by people with disabilities.[9]

General trends in computer technology indicate continued **rapid advancement in the development of smaller, faster, more powerful, and more user-friendly machines**. In addition, **the operating environment for computer software is becoming more graphic**, as reflected in Windows™ (Microsoft Corporation) for IBM and IBM-compatible computers and the graphic orientation of Apple and Macintosh computer software. **This type of environment or *platform* allows several programs to run simultaneously while reducing the complexity of operation associated with the more traditional disk operating system (DOS) platform**. These new platforms are beginning to support the "multimedia computers" that can access large amounts of information stored on CD-ROM. They also run complex software programs that produce computer-generated videos and allow visual composition and reproduction of music and other sounds. Furthermore, a new technology called Virtual Reality allows the user to interact directly with and become part of a computer-generated environment by using a *data glove* or *data body suit* and headset that displays the computer image. Persons with severe physical disabilities are currently using Virtual Reality to practice daily living skills.[12] Other areas of future development include computers that interact with the user through direct language (natural language communication systems) and computers that synthesize speech or use artificial intelligence (simulated intelligent human behavior). The medical community increasingly is using computers to create medical databases to collect information on medical conditions and related treatment strategies, symptoms, and outcome probabilities of various illnesses.[13]

Although some of the computer technology just described is still in its early developmental stage, existing computer technology in rehabilitation can generally be grouped into two general areas: **(1) counselor-oriented applications and (2) client-oriented applications.**

Counselor-Oriented Applications

Computers are frequently used in rehabilitation facilities and agencies to **manage information,**[3,12] **automate office procedures, and execute administrative procedures**. The powerful ability of computers to accurately process large amounts of information in a short amount of time makes this method of information management more cost-effective and efficient than other means. Clerical work, billing, accounting, bookkeeping, caseload management, and budget preparation/spreadsheet tasks lend themselves well to the computer. By performing these tasks on computer and managing this information more efficiently, rehabilitation personnel may be able to provide services in a more timely and efficient manner to people with disabilities.

WORD PROCESSING:

Many commercial software programs are available for word processing on the computer. **Word processors greatly reduce the time it takes to perform clerical tasks and to prepare case notes, Individual Written Rehabilitation Plans (IWRP), and reports**. As an added advantage, all documents produced through word processing can be stored on disk and are available later for review or editing. Proper management of these documents and disks can greatly reduce the use of paper and routine filing, and repetitive information can easily be passed from document to document without rewriting. **A new generation of powerful word processors operating in graphic environments is capable of performing desktop publishing functions, thus allowing the rehabilitation counselor to produce professional-looking**

reports, case notes, brochures, and fliers at a fraction of the cost of professionally printed materials. These programs include Microsoft Word for Windows™ (Microsoft Corporation), WordPerfect for Windows™ (WordPerfect Corporation), and Ami Professional™ (Lotus Corporation).

DATABASE PROGRAMS/COMPUTER INFORMATION NETWORKS:

Relational database programs have traditionally been difficult to operate and intimidating to computer novices. These programs typically have not been used by rehabilitation counselors on personal computers because many of the database tasks were handled by administrative personnel on large mainframe computers. However, with the increasing use of personal computers, **these programs can be a useful tool to many rehabilitation professionals for storing and retrieving client and caseload information**. Improvements in the ease of operation of database software and the introduction of databases that operate in graphic, user-friendly environments have contributed to more widespread use of such programs. **Database programs allow counselors to sort, query, combine, and print information from various databases stored on a personal computer**. Examples of database programs for personal computers include dBase,™ Paradox,™ and Microsoft Access™ (Microsoft Corporation).

On a larger scale, rehabilitation professionals can gain access to information through **computer information networks**. **These networks contain information stored in national databases on larger computers. Counselors can download to their computers up-to-date information about disabilities and assistive technology, professional journal articles, etc**. Databases such as ABLEDATA and the Job Accommodation Network (JAN) are particularly helpful for information on assistive devices and job accommodation information. **Additionally, database information on local and national job openings is available through electronic bulletin boards that can be accessed easily by a personal computer's modem**. Computer-based job-matching programs such as CapCo™ (The Capability Corporation) contain large databases (e.g., the Dictionary of Occupational Titles [DOT] and related occupational information [physical capacities and other selected occupational characteristics], as well as local employer databases for each state).

Counselors can communicate and exchange information with other rehabilitation professionals through electronic mail systems accessed through network services. These networks are available statewide, nationwide, and worldwide. Moreover, they are able to transfer information at a fraction of the time of paper communications. Information from database sources throughout the country can be downloaded immediately for use by the rehabilitation counselor through these networking procedures.

CASE MANAGEMENT:

Rehabilitation counselors typically spend large amounts of time performing case management activities. Managing large caseloads frequently takes time away from direct client contact and delivery of direct services. Herrick and colleagues[13] stated that **managing a caseload usually entails knowing client statuses, arranging services, regular-interval case reviewing, monitoring client progress through the rehabilitation process, and maintaining fiscal responsibilities**. The rehabilitation counselor can easily manage these tasks on the computer using special programming or existing commercial software programs. For example:

- **Word processing programs** can be used for case documentation.
- **Form generator programs** can produce standard forms (IWRPs, form letters, vouchers) that automatically retrieve and fill in client demographic information and service costs stored in database programs.
- **Database programs** store and retrieve commonly used client information, eliminating repetitive writing of information as well as producing client and employer mailing lists.

- **Communication programs** can link computers within offices or throughout the state for exchange and retrieval of information with field and central offices regarding job information, job accommodations, labor market information, journal articles, and case studies.

By using the computer, the counselor can:

- **Produce client and status listings in any order**.
- **Review certain cases with preset reminders** such as time in status or expiration of IWRP.
- **Produce reports on a client's progress** through the vocational rehabilitation system.
- **Obtain printouts that break out and sum individual and total cost** for each client in the system.
- **Obtain information on products and services** available through specific vendors and exchange information with other counselors.
- **Use time management programs and electronic calendars** to assist in scheduling client meetings and other appointments.

Chan and coworkers[9] used four major modules that included computer applications in a caseload management system. These modules included:

- The **general utility module** (policy reminder, form writer, and calendar program)
- The **expert consultant module** (disability-based or other variables)
- The **feasibility determination modules** (clinical and statistical outcome predictors and intervention)
- The **vocational planning and placement module**

COMPUTER-BASED JOB MATCHING:

Job matching refers to **matching a client's vocational profile with the specific requirements or profile of certain jobs**, otherwise known as the ***trait-factor approach to job matching***. Such information as the client's work history, aptitudes, physical capacities, educational achievement levels, temperament, and desired work situations is considered during the process. Before computer-based job matching systems existed, job matching was frequently done by visually comparing client profiles to occupational profiles and recording specific matches. This process was time consuming and subject to human error. Also, **the amount of information available made it impossible to compare a client profile with all occupations in the DOT. However, by using a computer, the rehabilitation counselor, vocational evaluator, or client can compare, within a matter of seconds, specific traits and profiles to profiles of all the nearly 13,000 occupations listed in the DOT**. Not only does the computer increase accuracy, but it **allows consideration of a large number of variables during the job-matching process**. Using the computer to produce job matches also **increases the objectivity of the process**, lessening the possibility that people with certain disabilities will be earmarked unconsciously for traditional, stereotypical jobs. Burkhead[12] enumerated the following uses for computerized job-matching systems:

- **Conducting job searches related to placement needs**. Depending on the system, the system user may **obtain a printout of jobs that the client can perform** and/or information on employers that might need those jobs performed.
- **Developing a profile of the client's transferable skills**. Some programs allow the user to develop a composite of the client's vocational skills by **entering previous jobs into the computer**. This profile can then be modified to reflect the client's current limitations.
- **Providing occupational information**. Although job-matching systems were not designed specifically to provide occupation information, they can be helpful as an initial step in that process. The job list with occupational codes serves as the basis for locating additional occupational information.
- **Career planning and counseling**. Using the client's vocational characteristics profile, which is based on current functioning level, **the counselor can systematically modify the profile to demonstrate how increased job skills relate to increased job opportunities**. This same

process can be used to help a client plan vocationally for decreased physical functioning caused by some (degenerative) diseases.

- **Providing information on education/training.** Some systems provide information on educational and training programs related to specific occupations on the client's job list.

A variety of commercial job-matching programs are currently available. These programs may be purchased as a stand-alone system or may be subscribed to for a fee and accessed by computer modem. Examples of such systems include CapCo,™ Occupational Access System™ (OASYS) (Vertek, Inc.), and Realistic Assessment of Vocational Experiences™ (RAVE).

COMPUTER-BASED ASSESSMENT:

Vocational assessment programs have generally focused on **measures that assess individual traits predictive of job success.**[14] During the assessment process, information is collected and integrated with other findings about certain individual traits and characteristics of the client. Tests that measure physical capacity, specific aptitudes, general educational development, interests, intelligence, personal values, and personality traits are frequently used in the assessment process to match a person with certain occupations. Many of these tests have been adapted from a paper-and-pencil format to a computer format. **Computer-based tests allow single or multiple administrations, automatic data collection and scoring, data analysis, data integration, and generation of test summaries and narrative reports.** Many computer-based tests produce immediate results and interpretations, whereas others use telecommunication methods to send test information to a processing center, which then returns a report of the results. Chubon and colleagues[14] specified the following benefits of computer-based testing:

- **Increased efficiency** (i.e., rapidly available results)
- **Increased scoring accuracy**
- **Increased measurement accuracy**
- **Elimination of the drudgery of manual scoring**
- **More complex, accurate, and refined analysis of test data**

Examples of computer-based assessment tools include APTICOM™ (Vocational Research Institute), Microcomputer Evaluation and Screening Assessment™ (MESA), and System 2000™ (VALPAR, Inc.). **These systems use computer methods with equipment designed specifically to assess aptitudes, interests, and educational levels previously obtained through paper-and-pencil methods.** Interest inventories such as the Career Assessment Inventory (CAI), the Vocational Research Interest Inventory (VRII), and the Strong Interest Inventory (SII) are available in computer format to allow immediate processing of interest information that previously took several days to obtain by conventional administration and scoring methods.

Invasion of the assessment field by computer technology has placed **increased responsibilities on assessment and evaluation professionals.** First, **professionals in this field must have a good working knowledge of personal computers, available software, computerized testing programs, and available assistive technology.** Second, although **traditional assessment tools** suggest a person's limitations, they **do not indicate to what extent assistive technology could enhance a person's performance.** Evaluation and assessment personnel must possess a thorough knowledge of assistive technology and how computers can be used to assess and compensate for the limitations that certain disabilities impose.

COMPUTER-BASED TRAINING:

Computer-based training is an effective teaching technique that has been available for almost two decades[15-18] but has not been widely used because of its high cost. However, as the cost of computer equipment has decreased, this type of training has become more feasible. The **primary advantages of this computerized instruc-**

tion over traditional classroom instruction are:[16]

- **Individualized instruction**
- **Automatic interaction**
- **Immediate feedback**

Professional competence has been conceptualized in three domains: (1) **the *knowledge* domain** (what one knows), (2) **the *skill* domain** (what one can do), and (3) **the *affective* domain** (how one's personality would affect professional behaviors in clinical situations). Along with situational variables, **these three domains interact to determine actual professional performance in clinical situations**. The three domains traditionally have been addressed through classroom instruction and subsequently evaluated through written examinations. However, **written examinations have proved less useful in evaluating the skill and affective domains than in evaluating the knowledge domain**. Thus, written tests are of limited value in predicting clinical performance.[19,20]

An alternative method is the use of **standardized case simulations, which have proved effective for evaluating the skill and affective domains of professional competence.**[4,20] In these standardized simulations, **the student is presented with a simulated clinical practice case** (including background and other related information) **on computer and then must make decisions** (presented as choices on a menu) **as would be done in actual practice. Students can learn case management skills**, such as gathering appropriate clinical information and appropriate status movements,* that can then be systematically observed and evaluated without any threat or inconvenience to actual clients. **The simulations can be designed in numerous ways to simulate various situations and disabilities, are performed in controlled settings, and automatically can collect data for immediate feedback to students for evaluation of their overall performance**. Because practicing rehabilitation counselors manage a number of cases simultaneously, the *single-case* simulation programs have led to *multiple-case* simulation programs that contain varying sizes and types of cases to simulate entire caseloads and associated counselor responsibilities.

The knowledge domain can be addressed by using **"grill and drill" techniques** on the computer. A counselor or student can use the computer to obtain information, such as specific disability descriptions and their related medical, psychosocial, and vocational implications. The information is presented systematically to aid the learning process. Later, **the program can provide the user with methods of self-evaluation** (such as a test), so that the student obtains feedback on what he or she has learned and can review identified areas of weakness to strengthen knowledge in a particular area. A person can use this program as needed, as a reference source, or to refresh knowledge.

Client-Oriented Applications

COMPUTER-ASSISTED VOCATIONAL GUIDANCE AND INFORMATION SYSTEMS:

Computer-assisted vocational guidance and information software is designed for **direct interaction between client and computer[3] and helps clients learn not only about the job market but also about themselves**. These systems provide a type of assessment, structured search, and occupational/educational information.[12] By using specific software programs, **the client can input information about work and personal values, interests, and aptitudes. The computer then chooses occupations and related fields that reflect the client's input and allows the client to explore them**. For each occupation, clients can receive a full description of the job; informa-

* In the state vocational rehabilitation system, clients are in different phases of the rehabilitation process. Each phase is referred to as a *status*, and each status corresponds to the type of service or activity in which the client is involved (i.e., status 06 is extended evaluation, status 18 is training, status 22 is employment). When a client moves from one status to another, it is known as a *status movement* or can be referred to as a *change in status*—these must proceed in a particular order.

tion on physical capacities, training and job placement options, and future employment opportunities; and statistics on employment and wages. This type of activity **assists clients not only in realistic vocational decision making and goal setting but also in planning appropriate action strategies for goal attainment.**[21] Also, clients are exposed to and can consider occupational options consistent with their abilities rather than their limitations.

COMPUTER-ASSISTED COUNSELING:

Several computer-assisted counseling systems are available, but **this method of counseling is still considered experimental and controversial**. Many people find it difficult to accept a "thing" in what is predominantly a person-centered process.[14] **Criticisms include the computer's inability to provide the user with a client-counselor relationship and the limited number of available responses to input data because of the natural language communications deficits in current systems**. Although the computer may never substitute for human contact and interaction, the rapid advancement of computer technology will, most likely, quickly increase the sophistication of this technique beyond the experimental stage and provide appropriate counseling support for persons who need less intense and more structured counseling.

As with vocational guidance and information systems, **the client interacts directly with the computer to help develop or change behaviors.**[22] The computer gives certain preprogrammed responses in accordance with the input provided by the person. The counseling software programs and their counseling "techniques" are based on specific theoretical frameworks that directly influence the way the computer responds to input. **Some computer-assisted counseling programs incorporate aspects of one or more of the following frameworks:**[12]

- **Psychoanalytic theory**
- **The client-centered approach**
- **The problem-solving approach**
- **Cognitive-behavioral approaches**

Advantages of such systems include their **step-by-step instructional processes, the unlimited time available for interaction, and their immediate accessibility to people with disabilities.**[3]

ADAPTIVE DEVICES FOR COMPUTERS:

As stated earlier, computers are being used increasingly to enhance the functional capacities of people with disabilities. **Numerous adaptive and functional devices are commercially available from a variety of manufacturers and in a wide range of prices and qualities. It is important that the user of an adaptive device be actively involved in the decision about what device to purchase in order to ensure its maximum utility**. As with other types of adaptive equipment, **the user's specific needs should be taken into account** before purchase lest the user reject the adaptive device, thereby depriving himself or herself of its potential benefits. Counselors should consider whether the client will find the adaptation useful or simply a nuisance. Chubon and colleagues[14] point out **three reasons why an adaptive device may be rejected**:

- **It may lack acceptable aesthetics.**
- **It may result in additional problems or burdens.**
- **It may draw unwanted attention to the person's disability.**

Scherer and McKee[23] suggest that, before adaptive equipment is purchased, **the rehabilitation counselor (or other purchaser) thoroughly assess the client's needs by considering the following:**

- **Characteristics of the device**
- **Characteristics of the client's temperament**
- **Characteristics of the disability**
- **Characteristics of the client's psychosocial arena**

Chan and coworkers[3] state that people with disabilities must have ready access to computers if they are to integrate effectively into present and future society. Computer users communicate with the computer through a device called an *interface*, the most common of which is

the computer keyboard. However, **many users with disabilities are unable to interact through the keyboard and, consequently, need alternative types of interfaces**. Two approaches have been used by product developers to increase accessibility to computers.[12] **The *special* or *modified approach* consists of modifying software to enable the computer to accept input from special devices such as light pens or joysticks. This is the least desirable method because it usually entails expensive reprogramming of standard software programs. The *transparent approach* entails designing devices that communicate with the computer in the same manner as a keyboard**. The computer and software cannot detect any difference in the communication method. This method is generally preferred because it is less expensive and allows the user to gain access to all software programs without expensive reprogramming.

Other types of adaptive devices on the market accommodate a wide variety of sensory/motor limitations. For example, **ergonomically designed keyboards are now available for persons with carpal tunnel syndrome or other wrist impairments**. Devices are also available to operate computers by **enlarged keyboards, single-switch entry devices, brow switches, sip-and-puff technology, pressure plates, paperless Braille terminals, and voice input**. One of the most sophisticated voice input/recognition programs is the DragonDictate™ system, which includes hardware and software that recognize the user's spoken words, permitting the computer to be operated by voice. Persons using such a system can achieve competitive typing and word processing rates without touching the computer keyboard.

Electronic readers have been available for several years for persons with visual impairments. Recent technology has produced a portable electronic reader called the Reading Edge™ (Sun SPARC) that is less expensive than previous devices. This device consists of speech synthesizers, a Braille keypad, and a scanner to translate written material into audible form.

The Eyegaze Computer System™ (LC Technologies, Inc.) represents one of the most sophisticated computer adaptations for people with physical disabilities, enabling them to **perform many computer functions using their eyes rather than their hands**. A video camera mounted below the computer screen observes one of the user's eyes while a low-power infrared light-emitting diode (LED) mounted in the center of the camera lens illuminates the eye, providing a bright image of the pupil and thus a bright spot reflecting off the cornea. On the basis of images on the eye's pupil and the corneal reflection, sophisticated image processing software continually computes where the user is looking on the computer screen. By simply looking at control keys on the computer screen, the user can perform a broad variety of functions, including synthesizing speech, controlling the environment, playing games, word processing, using the telephone, and operating most DOS-compatible software (LC Technologies, 1993).

AUGMENTATIVE COMMUNICATION DEVICES:

People whose ability to communicate through conventional means is impaired because of motor problems or an inability to verbalize can utilize **augmentative communication aids that take advantage of current computer technology.** These communication aids consist of **devices that produce synthetic speech or print the words on a display as the person inputs the information**. In addition, **certain phrases or words can be produced by pressing one button or key instead of typing the complete message**, thus increasing the rate of communication. These voice synthesizers are usually small and portable. Although technical advancements have improved the speech quality and made these devices less expensive, they still tend to slow down the rate of communication, making it difficult to achieve a normal-paced conversation. Current trends indicate that developers are taking their cues from the hand-held or "notebook" computer when designing communication aids. These devices not only aid in communication but also can be

used as regular computers for word processing or other computer functions.

ENVIRONMENTAL CONTROL/DAILY LIVING SKILLS:

Gaining control over the environment can dramatically increase the independent living potential of people with disabilities, improve their ability to perform daily living skills, enhance their self-esteem, and increase opportunities for social interaction.[3] **Computer systems are available to assist people in operating light switches, appliances, and thermostats. These systems can be preprogrammed to perform certain functions automatically at certain times and days of the week, thus reducing the need for attendants and increasing independence.**

Irons[24] observed that for people with limited or no functional motor capacities, **home security** is a major concern. **With computerized home monitoring systems,** people with disabilities can take advantage of **automated emergency call systems** and **automated door/window locks**, thus decreasing their feeling of insecurity and increasing their control over their environment.

ELECTRONIC BULLETIN BOARD SERVICES:

One goal of the National Institute on Disability and Rehabilitation Research (NIDRR) is to improve the telecommunication methods and technology available to people with disabilities.[25] NIDRR's attainment of this goal will enable people to have access to information that can potentially enhance their quality of life and aid empowerment.

By using a personal computer and a modem, a person can **connect with various electronic bulletin board services, such as information networks, job-opening listings, and electronic mail (E-mail) services**. Furthermore, a person can **gain access to information about most disabilities such as available adaptive devices, federal program information (SSI, SSDI), and related disability issues. This information can be directly transferred to and from the bulletin board and the user's personal computer**. For the large number of people with disabilities who are homebound, these electronic services provide a means for them to **communicate with others outside the home, shop and bank from home, and obtain on-line education and reference information.**[26]

Access to electronic bulletin board services previously was limited because of high-priced communications equipment and a lack of communication systems designed primarily to distribute disability information. However, because of today's lower-priced computer equipment and an increase in disability-related database information, use of this type of service will, most likely, increase significantly in the near future.

Ethical Considerations

As rehabilitation professionals collect information on computer about their clients, **maintaining the confidentiality of that information may pose a problem. Unauthorized access to data** on a computer may come from having several users share the computer, the networking of computers, or communication links with other computer systems. Because information can be sent so easily by computer, increased electronic release of confidential information may become a future concern. Agencies may need to address that possibility by **establishing policies on the electronic release of information, storage of computer data files, and maintenance of passwords for authorized computer users.**

Computerized assessment techniques make administering certain evaluation tools, (e.g., interest and personality inventories) relatively simple. However, the ease with which these tests can be administered by computer could encourage unqualified persons to give them and interpret the resulting computer-generated reports. Also, the impressive quality of some printouts and

reports may foster a **false sense of reliability and validity.** Computers are subject to the "garbage in, garbage out" principle. The information on computer-generated printouts is only as good as the initial information that went into producing the report and the integrity of the computer program itself. Chan and coworkers[3] point out that **many sources of errors in computer information exist: mistakes in data entry, programming errors, poor software/hardware planning, and insufficient research in software/hardware development.** Botterbusch[27] notes that some software developers, in an attempt to appeal to a broad base of customers, sacrifice accuracy for flexibility of input data. **Rehabilitation counselors need to develop skills in selecting quality software/hardware and in interpreting information generated from these sources. Any information resulting from testing procedures, whether or not it was generated by a computer, should be interpreted only by qualified professionals.**

Computer-generated information should be viewed critically, in much the same way that other client information is viewed. **It should not be looked upon as information that will provide decisive answers to problems encountered throughout the rehabilitation process.** Regarding computers as but one tool that assists rehabilitation professionals in performing their jobs will help maintain the integrity of computer usage in rehabilitation.

Summary

Computers and related technology have greatly enhanced the quality of life for people with disabilities. As advances in technology continue to be made, the skills of those who have disabilities will be further increased and their limitations further decreased. Much of this technology is currently being utilized in various vocational rehabilitation systems throughout the country to promote more efficient and effective case management, acquisition of information, job matching, and counseling. Thus, to deliver services to their clients as effectively as possible, rehabilitation counselors must keep abreast of current computer equipment and assistive technology. To ensure that computers are used responsibly in rehabilitation counseling, counselors need to be aware of their limitations as well as their benefits.

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Questions Based on this Lesson

25. Database programs are designed to do all but which of the following?
    A. Store and retrieve client caseload information
    B. Sort and combine information from various databases on a personal computer
    C. Provide self-help for clients through "counseling programs"
    D. Provide information on local and national job openings through electronic bulletin boards

26. Which of the following is false?
    A. Computer-assisted vocational guidance software allows the client to input information about abilities and interests, and then chooses sample occupations for the client to explore
    B. Computer-assisted counseling programs have been demonstrated to be superior to human contact and interaction in developing or changing the client's behaviors
    C. The purchaser of an adaptive device should make sure to consider the characteristics of the device, the prospective user's temperament, the disability, and the user's psychosocial arena
    D. Adaptive devices to operate computers include: enlarged keyboards, sip-and-puff technology, Braille terminals, and voice input

27. Which of the following is *not* regarded by the authors as an advantage of computer-based training for counselors?
    A. High cost of specialized software
    B. Individualized instruction
    C. Ability to learn case management skills without inconvenience to actual clients
    D. Immediate feedback

28. When using computer applications, the rehabilitation professional should be careful to:
    A. Establish policies on the electronic release of information, storage of data, and maintenance of passwords for authorized computer users
    B. Encourage unqualified persons to administer the tests and interpret the resulting computer-generated reports
    C. Realize that the tests are always reliable and valid, and thus provide the most solid basis for any conclusions drawn
    D. All of the above

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 8

A Rational-Emotive Approach to Anger Management

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Editor's Note

Most counselors are familiar with the difficulty clients encounter in overcoming anger and the problems this emotion can cause both in and out of therapy. Anger often becomes an obstacle to recovery, blocking client objectivity and concentration. When a client becomes accustomed to anger, perceptions of others and reactions to events are often adversely affected, thereby adding to the perceived and real problems of his or her life. Clients must learn to avoid reacting to negative events with anger if they are to improve their psychological state, enhance their lives, and make the rehabilitation process work for them.

In this lesson, the authors discuss rational-emotive therapy (RET), a unique method available to counselors to help clients surmount their anger problems. RET teaches people how to perceive *activating events* (i.e., those that can cause intense anger) in a more productive, beneficial fashion. Instead of employing *irrational Beliefs*, in which disturbing occurrences are viewed as awful and even damnable, clients learn to hold *rational Beliefs* that portray upsetting events as unfortunate, but not horrible. Constructive *consequences* result from such a change in one's belief system.

The rational-emotive treatment sequence involves 12 steps that teach the client to understand the relationship between the beliefs he or she holds toward disturbing events and their consequences. For example, once a person no longer perceives disturbing events as intolerable, he or she can react with frustration instead of with anger. This is important because a person whose actions are motivated by frustration—not anger—genuinely desires to remedy any situation that is bothering him or her. Thus, the rational-emotive treatment approach aids clients in coping with both upsetting events that one cannot control and recurring problems that can be avoided in the future.

Introduction

This lesson outlines the rational-emotive approach to dealing with clients' anger problems. We will provide a **brief overview of rational-emotive theory, outline how rational-emotive therapists conceptualize clients' anger problems**, and **present a summary of the 12 steps of the rational-emotive treatment sequence**. Practitioners who require a more comprehensive treatment of the topics covered in this lesson can find suitable texts in the references.

Basic Principles of Rational-Emotive Theory: An Overview

Rational-emotive therapy (RET) is a theory of personality and a comprehensive approach to psychological treatment that was developed by Albert Ellis, a clinical psychologist, in the 1950s. Although RET significantly **stresses the cognitive element in self-defeating behavior**, rational-emotive theory maintains that **cognition (or thinking), feeling, and behavior are interrelated and interacting processes, all of which must be taken into account if treatment methods are to be effective**.

The core assumption of RET is that **what we label "disturbed emotional reactions" are determined** not by the unpleasant events or circumstances that people experience in their lives, but mainly **by their irrational cognitions or evaluations about what they perceive is happening to them**. The **goals of treatment in RET** are: (a) To show clients that **disturbed emotions and self-defeating behaviors arise from and are maintained by the distorted inferences and irrational beliefs they hold about the activating events in their lives**; and (b) to help clients **surrender their irrational cognitions and replace them with more rational philosophies** that will help them emote and behave in more constructive and self-serving ways. Although the treatment process focuses primarily on cognitive methods, rational-emotive therapists persistently encourage their clients to use many emotive/evocative, imaginal, and behavioral assignments in order to work and practice what they learn in therapy and thereby replace their irrational ideas with more rational outlooks.

Goals, Purposes, and Rationality

Rational-emotive theory holds that human beings are happiest when they **establish important life goals and purposes** and **actively strive to achieve them**. RET acknowledges that we live in a social world and encourages us to pursue our own valued goals. In doing so, RET stresses to help others achieve their valued goals and to demonstrate a commitment to making the world a socially and environmentally better place in which to live. Given that we tend to be goal-oriented, ***rational*** in RET theory **means "that which helps people to achieve their basic goals and purposes**, whereas ***irrational*** **means that which prevents them from achieving these goals and purposes."**[1] Although rationality is not defined in any absolute sense, it contains **three major criteria: pragmatism, logic, and a basis in reality**. Thus a more extended definition of **rationality** would be: (a) **That which helps people achieve their basic goals and purposes**; (b) **that which is logical**; and (c) **that which is empirically consistent with reality**. Conversely, an extended definition of irrationality would be: (a) That which prevents people from achieving their basic goals and purposes; (b) that which is illogical (especially dogmatic); and (c) that which is empirically inconsistent with reality.

The ABC Framework

As noted above, we tend to perceive, think, feel, and behave interactionally. It follows that to understand and eliminate self-defeating or disturbed conduct, using a variety of cognitive, emotive, and behavior modification

methods within an overall conceptual framework is desirable. Because the **ABC framework** is the cornerstone of RET practice, it merits detailed attention.

"**A**" stands for an ***activating* event** that may be external or internal to clients. Here, ***A* also stands for the client's inference or interpretation about the event**.

"**B**" stands for ***beliefs***. They are **evaluative cognitions** (or thoughts) that are either rigid or flexible. **When such a belief is rigid, it is called an irrational Belief (*iB*)** and takes the form of a "must," an "absolute should," or perhaps a "have to." **When clients adhere to such rigid beliefs, they will tend to make irrational conclusions from these irrational premises**. These irrational conclusions take the form of: (a) **awfulizing** (more than 100% bad, worse than it absolutely should be); (b) **low frustration tolerance** (the client cannot envision being happy if what he or she demands must not exist actually does exist); and (c) **damnation** (damning oneself, others, and/or life conditions).

When a belief of the client is flexible, it is called a rational Belief (*rB*). A flexible belief takes the form of a **desire, wish, or preference that the client does not escalate into a dogmatic "must," "should," "ought," etc**. When clients adhere to such flexible rational Beliefs, they will **tend to make rational conclusions from these rational premises**. These conclusions may take the form of evaluations of badness, whereby, for example, your clients will conclude, "It's bad, but not terrible," rather than, "It's disastrous," when faced with a negative activating event. Another type of rational conclusion is a **statement of toleration**. The client may say, "I don't like it, but I can bear it." Yet another type is **acceptance of fallibility**, in which the client will **accept himself or herself and others as fallible human beings** who cannot legitimately be given a single global rating. Also, the client will **accept the world and life conditions as complex, composed of good, bad, and neutral elements**, and thus will also **refrain from giving the world a global rating**.

"**C**" in the ABC framework stands for **emotional and behavioral *consequences*** of the client's beliefs about *A*. In RET, **the *C*s that follow from irrational, rigid beliefs about negative *A*s** are termed ***unhealthy* or *self-defeating negative consequences***, and ***C*s that follow from rational, flexible beliefs about negative *A*s** are termed ***healthy* or *self-enhancing negative consequences***. It is important in the practice of RET to **bear in mind the distinction between clients' healthy and unhealthy emotional and behavioral reactions** to the various negative *A*s in their lives. Because the focus of this guide is on anger problems, the term ***anger*** and its various synonyms, such as rage, fury, hate, and resentment, **denote an unhealthy negative emotion that stems from *iB*s**; the term ***annoyance*** is used to refer to a **healthy negative emotion that stems from *rB*s**. Thus, anger and annoyance stem from very different types of cognition.

The Three "Major Musts"

In RET the essence of emotional and behavioral disturbance consists of **demandingness**.[2] Unrealistic expectations tend to result from an "absolutist" perspective—of unrealistic demands instead of rationally-assessed preferences and desires. Virtually innumerable variations of these core irrational Beliefs are expressed, and clients will often express their own particular iBs in personally distinctive terms. **Irrational Beliefs tend to be variations of three "major musts"**:

MAJOR MUST #1—DEMANDS ABOUT SELF:

The first major must concerns demands about oneself and is often stated in these terms: "**I must do well and be approved by significant others; if I'm not, then it is disastrous**. I can't stand it, and I am a damnable person to some degree when I am not loved or when I do not do well." **These beliefs often lead to anxiety, depression, shame, and guilt**. It is worth noting at this stage that **anger often serves to protect the client from perceived threats to self-worth**.

MAJOR MUST #2—DEMANDS ABOUT OTHERS:

The second major must concerns the client's **demands about others**, and is often expressed as follows: **"You must treat me well and justly. When you don't, I can't bear it**. You are damnable when you don't treat me well and **you deserve to be punished** for doing what you must not do." **Such beliefs are often associated with feelings of anger, passive-aggressive behavior, and acts of violence.**

MAJOR MUST #3—DEMANDS ABOUT WORLD/ LIFE CONDITIONS:

The third basic must concerns the **client's demands about the world or life conditions** and often takes the following form: "Conditions under which I live absolutely must be the way I want them to be; and, if they are not, it's terrible, I can't stand it—poor me." This belief is associated with feelings of **"hurt anger"** and **sulking behavior**.[3] The client may also have **secondary problems of self-discipline**, such as procrastination and addictions, that serve to protect them from their hurt and angry feelings.

Conceptualizing Anger Problems

In discussing the conceptualization of anger problems, we wish first to address three points. First, even though many words—such as rage, fury, and hate—are commonly used to describe anger, in this lesson we use the term *anger* throughout, because **in RET the irrational Beliefs that underpin anger are considered the same as those that underpin other emotional terms**. Second, **we will not focus on clinical problems in which physical violence is an integral component of a person's anger**, because this topic alone warrants a separate treatment if it is to be covered comprehensively. Third, as noted in the previous section, **rational-emotive theory considers anger to be an unhealthy negative emotion because it stems from a person's *iBs***. Conversely, ***annoyance*** is considered to be **a healthy negative emotion in that it stems from a person's *rBs***. Please keep this distinction firmly in mind, because it is at the core of the rational-emotive approach to treating anger problems.

We will now distinguish between three objects of a person's anger: (a) anger at others; (b) anger at impersonal objects and life conditions; and (c) anger at self.

ANGER AT OTHERS:

Some cognitive-behavioral therapists[4-7] have noted that **when people make themselves angry at others, the triggering activating events** or inferences about these events (point *A* in the ABC framework) involve **four major themes**. Those themes represent situations in which **other people**: (a) **Frustrate or block the client** in pursuit of his or her goals; (b) directly **attack the client** or what he or she values; (c) are deemed to **threaten the client** or what he or she values; and (d) **transgress the client's rules**.

Theme #1—Frustration

Clients who often make themselves angry when other people frustrate them in pursuit of their goals do so for two major reasons: (a) They have a **philosophy of low frustration tolerance (LFT)**, and/or (b) they are **blocked from achieving something to which they have attached their self-worth**.

Case Vignette:
LFT Anger in Response to Frustration

Pete frequently made himself angry whenever anybody got in his way (e.g., when he was riding his bike, when other people were standing in line in front of him at the supermarket, whenever anybody kept him waiting for a meeting). He made himself angry because: (a) He demanded that he *must not* be frustrated; (b) he evaluated being frustrated as *awful*; (c) this was something that he *could not stand*; and (d) he rated other people who frustrated him as *damnable*.

The therapeutic task with Pete is to **help him raise his level of frustration tolerance**. In this and in subsequent case vignettes **the aim of the counselor is to show clients that feelings of anger spring from their irrational Beliefs** about what they perceive and/or infer is happening at point *A*; and that **the only way they can eliminate or reduce their angry feelings is to dispute vigorously and give up the *iB*s that create and sustain those feelings. In the end, the RET counselor must teach his or her client how to replace the underlying iBs with more rational convictions or philosophies**.

In the case presented here, the RET therapist should endeavor to help Pete believe that: (a) **Frustration is undesirable, but no law of the universe states that he must not be frustrated**; (b) **frustration is an inconvenience, not a horror**; (c) **he can tolerate being frustrated** without ever liking it; and (d) **others are fallible human beings who have their own agendas** and will often frustrate him in pursuit of their goals. Once Pete has begun to internalize these rational Beliefs, he will be annoyed at being frustrated but will not make himself self-defeatingly angry whenever anybody gets in his way.

Case Vignette:
Self-Worth Anger in Response to Frustration

Lorna, a salesperson, had set her heart on gaining a promotion at work. However, one of her co-workers got the job. Lorna responded to this obstacle to reaching her valued goal with anger at her coworker and at her supervisor who failed to offer her the job. Lorna made herself angry because she had attached her self-worth to achieving a promotion. Her major *iB* was "I *must* achieve that which is very important to me and I'm *no good* if I don't." Consequently, she regarded her failure as *disastrous*, something that was *unbearable*; and she viewed others as *rotten* for preventing her from achieving something that she believed she had to achieve and exposing her to her own sense of inadequacy as a person.

Here, as elsewhere, self-worth anger is partially an attempt to place the blame on others rather than on oneself. In order **to help Lorna experience healthy annoyance (as well as sadness and disappointment) instead of self-defeating anger (and depression)**, her RET therapist should **strive to convince her that it would have been highly desirable for her to achieve her valued goal, but not necessary for her to do so**. Moreover, the counselor should encourage Lorna to **accept herself** as a fallible human being who has failed rather than perceiving herself as a complete failure. Having done this, it becomes easier to help her see that: (a) Failure is bad but not awful; (b) she can tolerate that which she believed she could not tolerate, and (c) her coworker and her supervisor are also fallible human beings who have a right to act according to their own set of values.

Theme #2—Direct Attack

As is the case of frustration, clients who make themselves angry when other people verbally attack them (or what they value) do so because they have a philosophy of LFT and/or they seek to preserve their self-worth.

Case Vignette:
LFT Anger in Response to Direct Attack

Ted made himself angry when his friend's 13-year-old daughter accidentally broke one of his valuable Chinese vases. He did so primarily because he believed that he *must not lose* (or have destroyed) that which he valued. Consequently, he believed: (a) It was *awful* that the girl broke his vase; (b) he *couldn't stand* to lose what was important to him; and (c) the girl herself was *no good* for being so careless. (Note, however, that Ted did not attach his self-worth to his vase and thus did not make himself angry to protect his self-esteem.)

In order to feel annoyed rather than angry in this episode, Ted would have had to believe that it would be highly desirable for him to retain that which he strongly values, but that there is no reason to support his claim that he absolutely has to do so. Then it would be easier for him to acknowledge that: (a) His loss was bad (but not awful); (b) his loss was something that could be accepted as having happened (but not liked); and (c) although the

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girl's carelessness was bad and unfortunate, she was a fallible youngster who would frequently do the wrong thing. **In this annoyed frame of mind, Ted could reasonably negotiate compensation from his friend,** something he would be less likely to do successfully if he were angry.

Theme #3—Perceived Threat

Clients sometimes make themselves angry when they **interpret the behavior of others as a threat to their sense of comfort** (a term broadly defined in rational-emotive theory), or self-worth. **Threat-related anger differs from attack-related anger in that a direct attack has not yet occurred in the former but is deemed by the person concerned to be on the horizon.** Beck[4] has noted that in threat-related anger, the person is not preoccupied with imminent danger. When the person is so preoccupied, it is more likely that he or she will experience anxiety. Rational-emotive theorists would concur with this view, although they would argue that **anxiety is experienced when the person holds irrational Beliefs about the danger.**

> *Case Vignette:*
> *Self-Worth Anger in Response to an Inferred Threat*
>
> Gina became angry at her husband when she saw him talking light-heartedly with an attractive woman at a party. She inferred that this meant he found the other woman attractive and wanted to have an affair with her. If this were true, she would see this as a threat to her self-worth.

Gina's jealous anger stemmed mainly from her demand that her husband *must not* find any other woman attractive; if he did, this would prove that she, Gina, was unattractive and worthless. Given this *iB*, Gina concluded that: (a) It would be *terrible* if her husband found another woman attractive; (b) she *could not put up* with such behavior; and (c) he was a louse for acting that way. Gina's irrational Beliefs encouraged her to form such inferences as, "He finds her more attractive than me," and, "He wants to have an affair with her." According to rational-emotive theory, Gina then assumes that these inferences are true and makes herself angry about these "facts."

When Gina discussed this incident with her RET therapist, he first encouraged her to assume that her inferences were true. Then he helped her **acquire the following major rational Belief that would lead her to be annoyed but not angry**: "I don't want my husband to find any other woman attractive, but there is no reason why he must not do this. If he does it, that doesn't prove I am worthless. I can accept myself if he does prefer this woman to me although I would be annoyed if that happened." From this major *rB*, she would make the following conclusions: (a) "**It is bad, but it is not terrible that he is acting in an undesirable manner;**" (b) "**I can stand his behavior, although I'll never like it;**" and (c) "**He's a fallible human being** who is acting in an unfortunate manner." With these *rB*s, Gina would be in a better frame of mind to question the validity of her inferences about her husband's feelings about and intentions toward the other woman based upon the evidence available to her.

Theme #4—Transgression Against a Rule

The final theme found in anger at others occurs when **others transgress a rule decreed important by the holder of that rule.**[4] The content of the rule may vary considerably among individuals, but it frequently involves the expectation that others will treat *one* with justice, fairness, and consideration. In addition, some people make themselves angry when they see that *other people* are being treated unjustly, unfairly, or inconsiderately. Another category of rules which, if violated, provide the trigger for a person's anger involves **situations when other people encroach on what the person considers to be his or her "rights"** (e.g., of autonomy, privacy, freedom of speech, freedom from prejudice, due treatment to which one feels entitled). As in the three categories discussed previously, **clients make them-**

selves angry when others transgress their rules because they have a philosophy of LFT and/or the transgression activates beliefs centered on lowered self-esteem.

Case Vignette:
LFT Anger in Response to a Transgressed Rule.

Marsha often sulks angrily when her brother treats her unfairly. Her rule that he transgresses on such occasions involves her anticipation that he will treat her with due consideration. Her major irrational Belief on such occasions is, "Because I treat him with consideration, he *must* reciprocate. I do not deserve his bad treatment and I must not get what I do not deserve." Marsha describes her feelings as a combination of hurt and anger. This "hurt anger" in Marsha's case does not involve self-devaluation but an attitude of "poor me." The irrational conclusions that Marsha makes from this primary demand are: (a) "It is *terrible* that my brother treats me in a manner I do not deserve;" (b) "I *can't stand* to be treated in this way;" and (c) "He is a *selfish creep* for treating me this way." Her sulkiness is an indirect way of punishing her brother for his behavior and an attempt to make him feel guilty.

Marsha sought therapy for her difficulties with her brother and was helped to change her *iB*s to the following *rB*s: (a) "I very much want my brother to treat me fairly, but he doesn't have to do so. Indeed, he has to act in the very way he does act because he responds to what goes on in his mind and not to what goes on in mine;" (b) "It's unwelcome, but hardly terrible that he acts inconsiderately to me;" (c) "I'll never like his bad behavior but I can tolerate it;" and (d) "He is not a selfish creep for acting inconsiderately but rather a fallible human being who has a tendency to act selfishly at times." With this set of rational Beliefs, Marsha set out to inform her brother in a determined manner that she did not like his inconsiderateness. **Her feelings of annoyance activated her to try to change the situation, whereas her old feelings of hurt and anger encouraged her to engage in sulky withdrawal.**

ANGER AT IMPERSONAL OBJECTS AND LIFE CONDITIONS:

In the previous section, we discussed how **anger at others is based on a philosophy of LFT and/or is an attempt to preserve one's self-worth by attacking those who trigger one's attitude of self-rejection.** Both of these basic reasons for anger are present when the focus of one's anger is on impersonal objects and life conditions.

ANGER AT SELF:

Clients often become angry at themselves when they **violate their own rules and standards and when they demand that they must not do so.** Such violations may refer to acts of commission (when they break their own rule by doing something) or acts of omission (when they break their own rule by failing to do something). **Self-anger resembles guilt in that both involve the person's demanding that he or she must act** (or must not act) **in a certain way and damning "self" as a consequence of failing to live up to such demands.** However, **in guilt** the rule that the person considers that he or she has broken **pertains to that person's moral code**, whereas **in self-anger** the rule generally lies **outside the moral domain.**

An Overview of the RET Treatment Sequence

Table 1 summarizes the RET treatment sequence. Because of space limitations we have limited ourselves to a few explanatory comments of certain aspects of the treatment sequence that, in our experience, merit extra attention. We will now comment briefly on these 12 steps.

STEP 1—DISCUSS GOALS FOR CHANGE:

While discussing your clients' goals for change, you may discover that even if your clients have agreed to focus on anger as their target problem, **they may be ambivalent about changing their feelings of anger and reluctant to**

Table 1
THE RATIONAL-EMOTIVE TREATMENT SEQUENCE

Step 1:	Discuss goals for change
Step 2:	Ask for a specific example of the client's anger problem
Step 3:	Assess *A*
Step 4:	Determine whether or not the client has a secondary emotional problem (and assess if appropriate)
Step 5:	Teach the *B–C* connection
Step 6:	Assess irrational Beliefs (*iB*s)
Step 7:	Connect *iB* and *C*
Step 8:	Dispute *iB*
Step 9:	Prepare the client to deepen his or her conviction in rational Beliefs (*rB*s)
Step 10:	Encourage the client to put his or her new learning into practice
Step 11:	Check homework assignments
Step 12:	Faciliate the working-through process

A = *Activating event (and inference)*
B = *Belief*
C = *Emotional and behavioral consequence*

give up their anger for a variety of reasons.[8] First, **they may not understand what constitutes a constructive alternative to anger.** If so, help them understand the **constructive aspects of annoyance** (i.e., it **aids effective action** and tends to lead to **improved interpersonal relationships** through a nonblaming discussion of what is happening in those relationships), and the **destructive aspects of anger** (i.e., it **inhibits effective action** and tends to lead to **deteriorating interpersonal relationships**).

Second, **clients often believe that they are supposed to feel and show anger and that showing anger is a sign of strength.** In this case it is worthwhile to devote some time to **challenging that view and offering a different one** (i.e., that **anger is a problem rather than a strength** in that it has negative intrapersonal and interpersonal consequences).

Third, **clients often believe that if they do not angrily condemn someone, the other person may not understand that the client disapproves of the other's actions.** Here you can discuss the greater advantages of assertiveness.

Finally, the client may believe that anger has good consequences. For example, **he or she may tell you how powerful it feels to be angry**, or how expressing things in an angry way is good. Here it is important to help them **distinguish between short-term and long-term consequences** and to show them that **the consequences that they list are in all probability short-term; the long-term consequences of anger are generally negative.** Thus, although they may feel powerful at the moment they are angry, they may later find themselves feeling powerful all alone, because **powerful displays of anger will tend to alienate other people.** Also, research tends to show that **cathartic displays of anger have long-term negative consequences for a person's physical and psychological health.**[9]

STEP 2—ASK FOR SPECIFIC EXAMPLES OF YOUR CLIENTS' PROBLEM:

Assuming that you and your clients have agreed to work toward changing their feelings of anger to those of annoyance, proceed to **assess a typical example of their anger problem. Clients tend to experience anger and hold related irrational Beliefs in *specific* contexts; therefore, being specific will help you obtain reliable and valid data about *A*, *B*, and *C*.** A good way of modeling specificity for your clients is for you to ask for a recent or typical example of their anger problem.

STEP 3—ASSESS *A*:

A, you will recall, stands for the **activating event** (or inference about the event) **that served to trigger the *iB*s that underpin your clients' anger**. When you assess *A*, keep in mind that the activating event (in the case of anger at others) is likely to involve any of the four major themes: (a) **frustration**; (b) **direct attack**; (c) **threat**; or (d) **transgression of a rule**.

It is important to note that **irrational Beliefs tend to lead to inferences that are negatively distorted.**[10] With respect to anger, this means that **clients may assume that when others frustrate them**, directly attack them, threaten them, or transgress their rules, **they**: (a) Are **unjustified** in doing so; (b) **do so intentionally**; and (c) have **malicious intent.**[4,7] You may be tempted to question the validity of this further set of inferences at this point, but resist that temptation. Rather, **encourage your clients to assume temporarily that *A* is correct**. Such encouragement will **help you to assess their irrational Beliefs more accurately**.

Identify the Part of A *that Triggered* B

Because we include clients' inferences as part of *A*, it is important to recognize that these **inferences are often chained** (or linked together). Assess this chain to **identify the most relevant link of the chain**; that is, the aspect of *A* that triggered the clients' irrational Beliefs at *B*, which, in turn, accounted for the angry feelings directed toward *C*. You can do this by using a technique called **inference chaining,**[11] a procedure that helps you identify how your clients' inferences are linked.

Avoid Pitfalls While Assessing A

Do not obtain too much detail about *A*. When clients do give you a lot of detail, try to **abstract the salient theme** from what is being said, or **summarize what you understand to be the major aspect of *A*** about which they may be emotionally disturbed. **Allowing clients to talk at length about *A* will discourage both of you from retaining a problem-solving approach** to helping clients overcome their anger problems. If this happens, interrupt the client tactfully and **reestablish a specific focus**. For example, you could say, "I think you may be giving me more detail than I require; what was it about this situation that made you angry?" However, at the same time, you should discourage clients from describing *A* in vague terms. **Obtain as clear and as specific an example of *A* as you can without being inundated with superfluous detail.**

In RET it is important for you to **work on one *A* at a time**. **Another pitfall, therefore, occurs when clients talk about several *A*s**. If this happens, encourage them to deal with the *A* that they consider to illustrate best the context in which they made themselves angry. Explain that you will deal with the other *A*s at a later date.

STEP 4—DETERMINE WHETHER OR NOT YOUR CLIENTS HAVE A SECONDARY EMOTIONAL PROBLEM (AND ASSESS IF APPROPRIATE):

It is important to check whether the client has a secondary emotional problem; that is, an emotional problem about their anger. **Frequent secondary problems about anger include guilt, shame** (if anger is expressed in public), **anxiety, and anger toward the self** for getting angry at others or life conditions.

If the client does in fact have a secondary emotional problem, and the existence of his or her secondary problems interferes significantly (either in the session or in the client's life outside) **with his or her primary problem, agree that this secondary problem will now become the focus of discussion**. You can carry out the assessment of this secondary problem using the ABC framework.

STEP 5—TEACH THE *B–C* CONNECTION:

Now that you have assessed the *A* and *C* elements of the primary or secondary problem, the next step is to **teach the client that his or her emotional problem is deter-**

mined by beliefs about the activating event rather than by the activating event itself. This is an important step. **Unless the client understands that his or her emotional problem is determined by internal beliefs, he or she will not understand why you are about to assess these beliefs in the next step of the treatment process.** Spend some time teaching the *B–C* connection if there is difficulty understanding it. You will also want to determine whether or not the client understands the points you are making about the *B–C* connection. **An important strategy is to ask clients to explain back to you in their own words the points you are making before proceeding further.**

STEP 6—ASSESS IRRATIONAL BELIEFS:

Ask clients questions to assess their *iB*s and give feedback with respect to their answers. Continue this process until you have correctly determined their *iB*s both in the form of a premise (e.g., a dogmatic "must," an "absolute should," etc.) **and the three main derivatives** from the premise **(awfulizing, intolerance of frustration, and damnation).**

You can ask clients two types of questions at this stage: **open-ended questions and theory-driven questions** (i.e., questions derived from rational-emotive theory). An example of an open-ended question is, "What were you telling yourself about *A* to make yourself angry?" A theory-driven version of the same question might be, "What *must* were you telling yourself about *A* to make yourself angry?" Both types of questions have advantages and disadvantages. The main **advantage of the open-ended question** is that **it encourages clients to think more for themselves in searching for the irrational Belief that underpins their anger. The main disadvantage is that clients may find it difficult to find the correct answer to your question and may require a good deal of extra help.** For example, in response to an open-ended question, the client may identify thoughts *other* than irrational Beliefs (e.g., inferences) as "causing" their anger. If so, you will have to educate him or her otherwise.

The main **advantage** of **a theory-driven question** is that it **quickly orients clients to look for their *iB*s.** The main **disadvantage** is that **the counselor may be putting words into their mouths.** If you encourage them to use their own words, this danger will be minimized. Whatever type of disputing technique you use, one important task that you have at this stage of the assessment process is to help clients discriminate clearly between their *iB*s and *rB*s. A more detailed treatment of disputing methods may be found in Dryden.[12]

STEP 7—CONNECT *iB* AND *C*:

The next task is to **help the client understand the relationship between unhealthy anger at C and irrational Beliefs at *B*.** The counselor should devote some time to help the client understand this connection before beginning to dispute any *iB*s. Otherwise, the client will not understand that these beliefs are being challenged.

STEP 8—DISPUTE *iB*:

The major goal of disputing is to help the client understand *why* his or her irrational Beliefs are self-defeating, illogical, and empirically inconsistent with reality; and why the alternative beliefs are self-enhancing, logical, and realistic.

Don't expect clients to have achieved deep conviction in the rational alternatives to their *iB*s at the end of this step. The goal of this step is for you to help them achieve intellectual understanding (or light conviction) that rational Beliefs are more viable and more productive than irrational Beliefs. The goal of the subsequent steps is to help deepen that conviction.

When disputing your clients' *iB*s, you should **endeavor to use open-ended, Socratic-type questions,**

although you may need to use short explanations to clarify various points. When you ask a question, ensure that you get a correct answer to the question you have asked. If not, **explain why the client's answer is incorrect and ask the question again in the same or modified form**.

Keep in mind two points while disputing your clients' irrational Beliefs: (a) **Use every opportunity to help them distinguish between their *rB*s and *iB*s**; and (b) **don't switch needlessly from disputing an irrational premise to disputing an irrational conclusion**. Keep on track.

STEP 9—PREPARE CLIENTS TO DEEPEN THEIR CONVICTION IN THEIR RATIONAL BELIEFS:

Once clients have acknowledged that: (a) there is **no evidence to support their *iB*s**, but **there is evidence to support their *rB*s**; (b) **it would be more logical for them to think rationally**; and (c) **their *rB*s will lead them to more productive emotional results** than their *iB*s, you may begin to help them deepen their conviction in their *rB*s.

Point Out Why a Weak Conviction in Rational Beliefs Is Insufficient to Promote Change

To help your clients understand this important point, briefly discuss the rational-emotive theory of therapeutic change. Given that we are not slaves to our tendency to think irrationally, **RET argues that we can change, particularly if we internalize three major insights**:

INSIGHT #1:

Past or present activating events do not "cause" disturbed emotional and behavioral consequences. Rather it is a client's belief system about these activating events that "creates" his or her disturbed feelings and behaviors.

INSIGHT #2:

Irrespective of how clients disturbed themselves in the past, **they *now* upset themselves largely because they keep reindoctrinating themselves with their *iB*s.**

INSIGHT #3:

Because clients are human and thus very easily—and to some degree naturally—tend to disturb themselves, and **because they find it easy to cling to their self-defeating thoughts, feelings, and actions, they can only overcome their disturbances by working hard and repeatedly both to dispute their irrational Beliefs and to counteract their effects.**

STEP 10—ENCOURAGE YOUR CLIENTS TO PUT THEIR NEW LEARNING INTO PRACTICE:

Once your clients have learned that **gaining conviction in the new rational Beliefs involves practice in disputing their irrational Beliefs** and replacing them with rational alternatives within and between therapy sessions, you can negotiate **homework assignments**, the aim of which is to **help clients translate *knowledge*** (intellectual insight) **into *conviction*** (emotional insight). For a detailed discussion of homework assignments and related issues, the reader is referred to several texts.[13–16]

STEP 11—CHECK HOMEWORK ASSIGNMENTS:

Because homework plays a key role in helping the client achieve therapeutic goals, it is very important to **monitor clients' experiences in carrying out their homework assignments**. In particular, it is important to trouble-shoot any obstacles to change that they identify.

STEP 12—FACILITATE THE WORKING-THROUGH PROCESS:

For clients to achieve enduring therapeutic change, they must **challenge and change irrational Beliefs re-**

peatedly and forcibly in relevant contexts at *A*. By doing so, they will further strengthen conviction in their *rB*s and continue to weaken conviction in their *iB*s. This is known as the **working-through process**, the purpose of which is to **help clients integrate *rB*s into their emotional and behavioral repertoire**.

At this point of the change process, you might wish to encourage your clients to read *How to Maintain and Enhance Your Rational-Emotive Therapy Gains*.[17] It contains many useful suggestions that your clients can implement to facilitate their own working-through process.

Conclusion

In this lesson, we have introduced some basic principles of rational-emotive theory and have focused on the rational-emotive approach to conceptualizing anger problems. We also have presented the rational-emotive treatment sequence as applied to therapy. Although RET may appear simple, it is a difficult approach to master. Therefore, we strongly recommend proper training for those new to RET. For further details about RET training, please write to:

Director of Professional Education
Institute for Rational-Emotive Therapy
45 East 65th Street
New York, NY 10021

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Questions Based on this Lesson

29. An irrational Belief (*iB*) differs from a rational Belief (*rB*) in that an *iB*:

    A. Is based on a perceived activating event that is actually nonexistent

    B. Tends to view an activating event as totally awful and worse than it absolutely should be

    C. Results from an activating event that is relatively insignificant

    D. Does not require an activating event to cause behavioral consequences

30. Which of the following views towards frustration is *not* advocated by the author?

    A. There exists no reason why someone must not be frustrated

    B. People are imperfect and thus will sometimes cause frustration in others

    C. Without frustration, one could not truly appreciate happy events

    D. Frustration is annoying, but not horrible

31. Which of the following statements about clients in rational-emotive therapy is *false*?

    A. They should deal with only one activating event at a time

    B. They should be asked only theory-driven questions—not open-ended questions

    C. They should be taught to replace feelings of anger with those of frustration

    D. Their homework assignments should be monitored

32. Consider the following scenario:

    Dan suspects that his wife Anne is having an affair with his best friend Jeff.

    Which of the following conclusions made by Dan does *not* necessarily stem from an irrational Belief (*iB*)?

    A. "I know she's having an affair behind my back; I'm worthless, especially compared to Jeff"

    B. "I cannot tolerate their flirtatious behavior at all, and I have every right to seek revenge"

    C. "If they are indeed having an affair, I will confront them immediately and convey my disapproval"

    D. "They're despicable, and they delight in causing me anguish and in humiliating me"

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 9

Alleviating Symptoms of Depression

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Editor's Note

The rehabilitation process is often fraught with obstacles. The experience of clinical depression as a result of or in addition to these obstacles further challenges both counselor and client as they seek to maximize the life skills and functioning of the client. Thus, it is often necessary for the counselor to focus on management of the depression or the depressive symptoms before implementing extensive rehabilitation strategies or career guidance.

The author emphasizes that the rehabilitation counselor and other members of the health care team have responsibilities both to ensure that all possible causes of the depression are explored (and treated with medication if appropriate) and to educate the client about noninvasive, safe, and inexpensive ways to alleviate some or all symptoms of depression. This lesson, which is based on the author's intensive study of 120 persons who experienced episodes of depression, presents a practical guide to depressive symptom management, and includes forms, charts, and checklists that may be photocopied by the counselor and distributed to clients.

Recognizing Symptoms of Depression

When working with clients in the rehabilitation process, the counselor must be aware of symptoms indicative of depression (Table 1).

Table 1
Common Symptoms of Depression[1]

- Hopelessness
- Worthlessness
- Lack of response
- Lack of motivation
- Low energy level
- Loneliness
- Excessive sleep
- Poor appetite
- Chronic sadness
- Anxiety
- Lack of affect
- Disorganization
- Excessive feelings of guilt, embarrassment or shame
- Uselessness
- Apathy
- Extreme fatigue
- Physical slowness
- Negative attitude
- Isolating behaviors
- Insomnia
- Excessive eating
- Feeling dead inside
- Irritability
- Low self-esteem
- Inability to make decisions
- Chronic aches and pains

These symptoms, especially if they continue for more than several days or occur at regular intervals, must be taken seriously. **Depression can be a major detriment to the rehabilitation process** and, of course, it **interferes with basic life enjoyment and attainment of life goals.**

Medically Based Causes of Depression

Counseling techniques alone are rarely effective if a biological problem underlying the depressive disorder remains untreated. A medically based depressive disorder can be **caused by chronic or acute disease processes; depression may be an early symptom of such disorders.[2] The counselor who observes symptoms of depression must refer the person for a complete medical evaluation as soon as possible.** Depression caused by illness or some other medical condition is much easier to treat and **responds more rapidly to treatment in the earlier stages**. Also, because **antidepressant medications often take from 3–5 weeks to work effectively**,[3] an early diagnosis will undoubtedly hasten recovery.

Hypothyroidism (thyroid insufficiency caused by diminished production of thyroid hormone) **is a common biological cause of depression, and can be uncovered by undergoing a complete battery of thyroid tests. Other endocrine or adrenal gland dysfunctions, food allergies, or seasonal affective disorder may also be implicated.** It has also been hypothesized that excessive exposure to electromagnetic radiation from electric blankets, water bed heaters, and video screens may also be a factor in some depressive disorders.[4]

The depressed person may be unable to make arrangements for a medical evaluation. Therefore, the counselor may have to take a direct approach by contacting health care providers for necessary appointments, arranging transportation, reminding the client of dates and times, and alerting family members and supporters.

A health care *team* is needed for any thorough evaluation. This team usually includes a **general practitioner**, and might include (depending on symptoms, history, and the recommendations of the general practitioner):

- A **psychiatrist**
- A **psychopharmacologist**
- An **endocrinologist**
- An **allergist**
- A **hospital facility**

Information on health care professionals who are most appropriate for such an evaluation can be found by networking with colleagues and contacting mental health organizations.

Clients rely on members of their personal health care team to:

- **Be willing and anxious to know and understand them very well**
- **Have experience and expertise in treating depression**
- **Be willing to consider and try alternatives such as light therapy, exercise, and peer counseling**
- **Use medication when necessary**
- **Support, counsel, advise, advocate, understand, and care**

Medications

It is important for the counselor to understand that **clients may fear the side effects of medications.** However, **medication may be necessary in the short- or long-term to allow the client to begin to control the condition and to enhance the rehabilitation process. Education is the best ally in this process. The client and members of the support team should be well-informed about medications before they are administered.** Counselors can refer the client and his or her family to resource books such as *The Physicians' Desk Reference*, *The Consumer Drug Digest*, and *The Essential Guide to Psychiatric Medications*, which are available at most libraries.

Medication and dosage changes must be performed only under the strict supervision of a physician. Regular tests and physical examinations are absolutely essential for anyone taking psychiatric medications.

Members of the support team must be educated about every aspect of the person's medical treatments so that they can make treatment arrangements and decisions when the depressed person is unable to do so. (Setting up a support team is discussed later in this lesson.)

Hospitalization may be necessary and should be encouraged for any of the following reasons:

- **The safety of the depressed person is in jeopardy**
- **Family members and friends may be unable to provide care**
- **Drug treatment may need to be monitored initially**
- **"Time out" in a safe, structured environment would be helpful**
- **Psychosis or severe agitation is evident**

Counselors must be aware of the facilities and programs of the hospitals in their area.

Education and Empowerment

It is important to remind depressed clients that **there is indeed hope: depression ends**; people who experience depression get well and stay well for long periods of time. In fact, many never have another episode after learning and implementing wellness strategies.

From studying people who experience depression, it is clear that **those who take responsibility for their own recovery ultimately attain the highest levels of stability, wellness, happiness, and control over their lives. Empowering the depressed client to undertake this responsibility, with the assistance of health care and support teams, is a key role of the rehabilitation counselor.**

Counselors should encourage the depressed client to learn about the medical, social, and personal elements of depression. This type of education may not be possible when the client is in the depths of a depressive episode, but at other times the counseling process can emphasize education to alleviate future symptoms as much as possible and to prevent recurrent episodes. **Education facilitates appropriate decision making about all aspects of depression, including treatment, lifestyle, education, career, relationships, living space, parenting, and leisure activities.** It also enables clients to ask the right questions and to know where to look for answers.

It is often helpful to **put depressed clients in touch with educational organizations that publish newsletters for people who experience depression**; encourage them to send each organization a postcard requesting a

complimentary copy. If the publication is helpful, encourage them to subscribe. They should also **attend depression-related workshops and seminars** where they can receive input from health care professionals and others who have experienced or are currently experiencing depression.

Charting

It is often quite useful to **develop and update a daily chart so that the client can respond early and appropriately to the subtle changes in mood that usually precede a depressive episode.**

Figure 1 is an example of a daily danger signs chart. Because the signs of upcoming episodes vary with each person, the following page contains an additional chart (Figure 2); both may be photocopied and distributed to clients. **Work with clients to raise their awareness of their own personal warning signs, and use them in the charts.**

Figure 1

CHART FOR DEPRESSION DAILY WARNING SIGNS

I will be honest with myself in this assessment. If I note that I am showing signs of depression, I will let my support system know, and I will take corrective action that I have learned or that is recommended by others whom I trust.

Date:

SYMPTOMS	*Sun*	*Mon*	*Tues*	*Wed*	*Thurs*	*Fri*	*Sat*
Overeating							
Lack of appetite							
Lethargy							
Difficulty exercising							
Fatigue							
Low self-esteem							
Procrastination							
Avoiding crowds							
Irritability							
Impatience							
Insecurity							
Difficulty getting up							
Insomnia							
Poor judgment							
Obsessive thoughts							
Repeating things							
Inability to concentrate							
Destructive risk taking							
Suicidal thoughts							
Paranoia							
Anhedonia (inability to feel pleasure)							

Figure 2

YOUR PERSONAL DANGER SIGNS CHART

I will be honest with myself in this assessment. If I note that I am showing signs of depression, I will let my support system know, and I will take corrective action that I have learned or that is recommended by others whom I trust.

Date:

SYMPTOMS

WHAT TO DO EVERY DAY

MEDICATIONS TAKEN

Dietary Considerations[1,4]

What we eat tends to affect how we feel. Depressed clients should:

- **Avoid eating any one food excessively or exclusively.**
- **Avoid overeating or undereating.**
- **Avoid sugar.** The subjects I studied overwhelmingly said sugar exacerbates depression, makes them hyperactive and foggy, reduces their ability to concentrate, and increases lethargy; some felt "hung over" after consuming sugary foods.
- **Limit the amount of caffeine** in the diet to a cup of coffee in the morning to get going and a cup of tea in the afternoon; avoid soft drinks with caffeine.
- **Be aware of foods that might be affecting their moods** and use simple avoidance testing for 2 weeks to determine the effects of particular foods on mood.
- **Focus on a diet high in complex carbohydrates: rice, potatoes, pasta, whole grain breads, and vegetables**; complex carbohydrate foods increase the levels of neurotransmitters (e.g., serotonin) in the brain, and thus may function like an antidepressant.
- **Avoid high-protein diets and liquid diet drinks.**

Counselors should note that clients taking psychiatric medications need to drink plenty of water and avoid fasting.

Light

The importance of full spectrum light through the eyes is being studied extensively at this time. **Exposure to light seems to increase the action of neurotransmitters in the brain, thereby alleviating depression.**[4] Counselors should be current with the latest information emerging in this field. ("Sleep Disorder and Light Therapy" will be available from *Directions in Psychiatry* in December, 1993.) Sources of full spectrum light include sunlight and light from specially manufactured full spectrum bulbs.

Remember these important points about light:

- **Advise clients to get outside for as much natural light as possible with glasses off and contact lenses out—even on cloudy days.** If a person cannot see well enough to walk without glasses or contacts, they should sit outside for 20–30 minutes. However, caution them to avoid sunlight in the summer months between 10 AM and 2 PM.
- Supplementing light with specially constructed light boxes may be necessary in northern latitudes.
- **Distorted spectrum light such as that found in fluorescent light bulbs should be avoided**; some reports indicate they make people uneasy.
- **Full spectrum or Vita-lite has a positive effect on mood stability and overall wellness.** (Full spectrum light bulbs that fit in fluorescent light fixtures can be purchased at hardware and health food stores.)
- **Employers should be encouraged to replace fluorescent light bulbs in the work place with full spectrum bulbs.**

Exercise

Exercise works extremely well in alleviating depression;[1,4,5] better yet, it is arguably the **cheapest and most available method** for doing so. **Those who experience depression should exercise daily for at least 20 minutes.** Any type of exercise they enjoy is acceptable; it need not be strenuous.

Relaxation

Relaxation techniques have proven very helpful to depressed persons.[1,6] Due to the nature and pace of contemporary society, many of us actually need to **make a special effort to learn how to relax**. However, it is not easy to learn how to relax during a depressive episode. Relaxation usually needs to be learned and practiced when the client is not experiencing full-blown depression, so that he or she will be able to use the methods successfully when depressed or stressed.

Counselors can easily teach relaxation techniques. These strategies can be learned by taking an instructional course, using an instructional video, and practicing the instructional exercises in books such as *The Depression Workbook* and *The Relaxation and Stress Reduction Workbook*. Structured periods of intense relaxation (10–30 minutes) should be built into the daily schedule.

Counselors should encourage clients to "slow down and take a few deep breaths" or to do a relaxation exercise when they start to feel harried. Relaxation exercises provide a break from depression and can interrupt a downward moodswing.

Cognitive Therapy

Negative and distorted thoughts often instigate a vicious downward spiral. They **worsen mood, thereby generating more negative thoughts. Symptoms of depression such as low self-esteem and self-confidence, hopelessness, fear, guilt, and embarrassment benefit from an intensive program of cognitive therapy** (changing negative thoughts to positive ones). "Cognitive Therapy for Depression," available from *Directions in Rehabilitation Counseling*, provides an excellent overview of using cognitive therapy in treating depression. Resources such as *Thoughts and Feelings: The Art of Cognitive Stress Intervention*, *Feeling Good*, *The Feeling Good Handbook*, and *Cognitive Therapy of Depression* are valuable guides to this very important work.

Some examples of negative thoughts common in depression—and their positive counterparts—include:

- "I have never accomplished anything" becomes "I have accomplished a great deal." (Working with the client to make a realistic list of accomplishments facilitates this process.)
- "I will never be well again" becomes "I will be well—depression ends. Other people get well and stay well for long periods of time, and I will too."
- "No one likes me" becomes "There are many people who like me." (Making a list of friends helps.)
- "I want to die" becomes "I want to live."

Changing negative thoughts to positive ones is often an elaborate, long-term process, but it is well worth undertaking. Remember that **cognitive therapy is one aspect of an overall wellness program and should never be considered as a substitute for a complete program of medical and psychological care**.

Affirmations

Development and regular repetition of affirmations (Table 2) may seem like a simplistic concept, but many who experience depression use this technique and find it to be **very beneficial**. It is **noninvasive and free**, so it is well worth a try.

In this process, clients make lists of **short positive statements that describe how they would like to feel and how they ideally envision their lives**. They develop the habit of filling empty spaces of time (stopped at a street light, washing dishes, upon awakening, bedtime, meditation time) with these affirmations—repeating them again and again. Some people carry lists of affirmations in their pocket or purse, or place them on the refrigerator door. *You Can Heal Your Life* is an excellent reference for affirmations.

Table 2
EXAMPLES OF AFFIRMATIONS

- I enjoy being alive
- I want to live
- I am happy
- I am well
- I am in control of my life
- I am loved
- I trust myself
- I take good care of myself

Chronic or Acute Stress and Trauma

Depression may be caused, triggered, or worsened by chronic or acute stress, life issues, or traumatic events such as:

- Child abuse
- Sexual abuse
- Spouse abuse
- Marital problems
- Overwork
- Lifestyle changes
- Rejection
- Experiencing or witnessing violence
- War
- Natural or manmade disasters
- Accidents
- Personal loss or tragedy
- Substance abuse (self or family member)
- Stigma

In many of these cases, depression is in fact an appropriate emotional response to the circumstance. Intervention at this point may focus on **"working through" the mourning period** and then **putting the events into perspective and resuming a functioning lifestyle.**

One of the purposes of counseling at these times is to **prevent recurring depressive episodes.** The counseling process may be enhanced by:

- Regular peer counseling sessions. The client sets up a peer counseling relationship with someone they trust who is nonjudgmental and willing to listen without giving advice. It helps to have a regular time every week; for example, an hour at 7:00 PM on Tuesday. The peer counselors spend equal time sharing and listening to each other.
- Attending a support group for others who experience depression through which they can receive encouragement, understanding, and information.
- Using self-help books. In addition to the list in the Resource section of *The Depression Handbook, I Can't Get Over It: A Handbook for Trauma Survivors* is very valuable for depressed clients. It validates the trauma of the experience, describes the after-effects of such experiences, and provides a treatment model that includes numerous self-help exercises.

Support

Support from family, friends, and health care professionals is essential to the recovery process. However, it is often difficult for depressed clients to gain and maintain a support system because:

- They have low self-esteem.
- Inappropriate behavior embarrasses others.
- They are needy and draining.
- Their behavior is unpredictable.
- They have a hard time reaching out for help.
- They become overly dependent on one or a few people.

It is often helpful for clients to **make a list of five people whom they can call on when they need support.** A network of at least five people is essential to prevent wearing any one person out; also, others are not always available or capable of being supportive. These lists, including telephone numbers, should be posted in convenient places.

Encourage clients to build their support system by:

- **Involvement in support groups**
- **Joining special interest groups**
- **Attending community events**
- **Being mutually supportive**
- **Keeping in touch with friends**
- **Scheduling contact with peers**
- **Developing appropriate social skills**

Depressed clients need and want love, understanding, acceptance, caring, support, activities, information, protection, feedback, and monitoring ("reality checks") from these supporters.

Figure3
SAMPLE DAY PLANS

Day when client is not working		*Day when client is working*	
7–8 AM	Get up, shower, eat (cereal with fruit, herb tea)	7–8 AM	Get up, shower, dress, eat breakfast (bagel with cream cheese, herb tea)
8–9	Contact support system, arrange people for peer counseling, lunch, and therapy visit, take a walk	8–8:45	Contact supporters for lunch and evening
9–10	Make beds, vacuum, pay bills	8:45–9	Drive to work
10–11	Peer counseling with close friend	9–10:15	Work
11–12 PM	Work on art project	10:15–10:30	Break, relaxation techniques
12–1	Lunch with close friend	10:30–12 PM	Work
1–2	Nap or relax with light novel	12–1	Lunch and walk with member of support team
2–3	Counseling appointment	1–2:30	Work
3–4	Errands (groceries, renew prescription at pharmacy, library, video store)	2:30–2:45	Break, relaxation techniques
4–5	Watch television	2:45–5	Work
5–6	Prepare dinner, eat	5–6	Counseling
6–7	Journal writing	6–8	Dinner out with a member of support team
7–9	Watch video with family member	8–10	Watch light video
9–10	Read light novel		

Planning

Depressed clients often find it very difficult to make plans; they sometimes cannot even remember the things they enjoy doing. **Accomplishing projects or chores each day, along with activities they enjoy, helps to enhance motivation.**

First, help them **make a list of things they like to do**. The list might include reading a light novel, watching situation comedies on television, going for a walk, gardening, watching videos, having lunch with a friend, playing ball, dancing, painting, shopping, or woodworking. The second list includes **chores they feel should be done**, such as washing the dishes, vacuuming, or making beds. Use these lists, along with the other components of the wellness program, to help the person make a plan for the day. Figure 3 illustrates examples of day plans that may facilitate functioning in cases of depression.

Suicide Warning Signs

Counselors need to be aware of the following suicide warning signs:[4]

- **Talk about committing suicide**
- **The loss of important person(s) or possession(s)**
- **Social isolation**
- **Severe agitation (very dangerous—immediate help may be required)**

- **Alcohol and drug abuse (vastly increase risk for suicide)**

The beginning of recovery is a very risky time—energy is increased, but thought patterns may still be quite negative.

Suicide Prevention

To prevent suicide and suicide attempts:

- **Insist on treatment of depression early before it gets out of hand**
- **Help clients put systems in place, including a suicide support team to prevent suicide (this system should ensure that they are never alone when they are suicidal, even if they insist they want to be alone)**
- **Educate clients and their family members on the importance of never leaving leftover medication or weapons accessible to the client**
- **Teach clients relaxation skills, the use of cognitive therapy techniques, and affirmations**
- **Encourage clients to have pictures of their favorite people in view**
- **Be sure clients keep appointments with all health care professionals**
- **Help clients have something planned to anticipate**

When a client is suicidal, family members, supporters, and health care professionals must take protective action, even if the person refuses such action: it may be necessary to save his or her life.

Summary Check List

Use the following list as a guide in working with a client with depressive symptoms.

- ✔ Set up a health care team
- ✔ Make sure systems are in place to prevent suicide
- ✔ Make sure that the client:
  - ✓ Has had a complete medical evaluation
  - ✓ Knows the wellness process is his or her own responsibility
  - ✓ Has ongoing education about the illness and has access to additional resources
  - ✓ Identifies early warning signs
  - ✓ Develops and uses planning charts
  - ✓ Considers dietary components
  - ✓ Exercises regularly
  - ✓ Gets full spectrum light through the eyes
  - ✓ Works on a cognitive therapy program
  - ✓ Develops and uses affirmations
  - ✓ Participates in regular psychological counseling
  - ✓ Has a support team of at least five people
  - ✓ Attends a support group
  - ✓ Has a regular peer counseling relationship
  - ✓ Knows how to make daily plans

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Questions Based on this Lesson

33. Which of the following is *not* cited as a valid reason to recommend hospitalization for a depressed client?

    A. The client represents a threat to his or her own physical safety.

    B. The client refuses to see his or her doctor.

    C. Drug treatments that have been prescribed may need to be monitored.

    D. The client is manifesting psychosis or severe agitation.

34. Which of the following statements is *true*?

    A. Many depressed persons who recover from depression never experience another depressive episode.

    B. The rehabilitation counselor is obligated to take the primary responsibility for the client's recovery.

    C. The counselor should be skeptical of referring clients to educational organizations that publish newsletters for people who are experiencing depression.

    D. Client education is useless when the client is depressed.

35. Which of the following statements is *true*?

    A. Caffeine has proven to be a reliable "pick-me-up" for depressed persons.

    B. Clients should try to eat a diet high in complex carbohydrates that includes potatoes, pasta, whole grain breads, and vegetables.

    C. Daily deep relaxation strategies often backfire with depressed persons because they discourage exercise and reduce energy.

    D. There is no way to obtain full-spectrum light other than with specially manufactured full-spectrum bulbs.

36. Which of the following is *not* an element in suicide prevention?

    A. Helping clients set up a support team

    B. Teaching clients relaxation skills

    C. Educating clients and family members about depression and suicide prevention

    D. None of the above

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 10

Placement Practices and Labor Markets for Clients with Disabilities

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Directions in Rehabilitation Counseling

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Introduction

Placement, as used in the field of vocational rehabilitation, has been defined and described in a variety of ways. Many placement models and programs have been proposed and implemented. This has resulted in a considerable body of useful information that must be organized into a practical framework so that consumers and practitioners can select and implement services effectively and efficiently. This lesson suggests such a framework, using labor markets and how they function as the underlying concepts that cement the framework.

Part 1 of this lesson illustrates how the rehabilitation practitioner's understanding of labor markets can benefit the rehabilitation process of the individual client. This section provides statistical data for identifying the employment needs of persons with disabilities, describes various placement models for vocational rehabilitation and how they have affected labor markets, compares rehabilitation programs with other types of placement services, and describes how the evaluation and job-seeking processes affect—and are affected by—labor markets.

Part 2 describes the role that the vocational rehabilitation agency itself plays in the labor market. The author argues that marketing techniques can and should be used to develop more productive relationships with employers, and he outlines the three basic components of this marketing process: *environmental assessment*, *strategic planning*, and *implementation*. Environmental assessment involves identifying opportunities and threats that influence the ability of the agency to achieve its goals. Successful strategic planning should include all departments of the agency and requires that the agency articulate its mission and communicate this vision throughout the agency. Implementing the coordinated action plan must be accomplished with a high level of communication both with clients and within the agency itself.

The Employment Needs of Clients with Disabilities

In 1988, census data reported that **approximately 13.5 million persons between the ages of 16 and 64 had a work disability**,[1] which amounts to roughly 8.6% of the United States population. Of these, 7.5 million (4.8%) had severe disabilities. **Only 32% of those reporting a disability, however, were working**; and a mere 10.2% of persons with severe disabilities were represented in the labor force. **Only 3 out of every 10 disabled men and 2 out of 10 disabled women of working age were employed full-time**.[2] This lack of participation in the labor force by those with disabilities as compared with those in the general population is further documented by the following statistics from the 1980s:

- 36% of men with disabilities were in the labor force compared with 89% of men in general.
- 23% of men with disabilities worked full-time compared with 75% of men in general.
- The unemployment rate was 14.2% for men with disabilities, whereas it was 6.2% for men in general.
- 27.5% of women with disabilities were in the labor force compared with 70% of women without disabilities.
- Only 13% of women with disabilities worked full-time, whereas 47.1% of women without disabilities did so.
- The unemployment rate for women with disabilities was 14.2%, whereas it was 5.2% for women in general.
- Income for persons with disabilities lagged behind that of others and increased at a slower rate.
- Although people with disabilities comprised 8.6% of the population, they comprised 21.9% of persons at or below the poverty level.
- 52% of employed men with a disability were covered by employer-sponsored health plans, whereas 66% of men in general were covered. For women, the rates were 40% and 53%, respectively.

The Harris poll commissioned by the National Council on Disability[3] confirmed in more graphic detail the problems persons with disabilities face as a result of their lack of participation in the economic and social mainstream. The national survey found that **only 25% of working-age persons with disabilities work full-time, with another 10% employed part-time. Two thirds of those not working said they would accept employment if it were offered**. Although disability itself was attributed by respondents as the major barrier to employment, **47% indicated that employers did not recognize their ability to work full-time**. In addition, 40% indicated a **lack of knowledge regarding how to find jobs**; 38% felt **they did not have the skills, education, and training** to get a full-time job; 28% attributed unemployment to **lack of accessible transportation**; and 23% indicated that **they would need special devices or accommodations** to work.

People with disabilities do not reach the 50% rate of participation in the labor force at any age, and, as they become older, their participation rates decline ever more steeply.[2] Annually, **over 500,000 Americans experience a disability that keeps them out of work for at least 5 months**.[4] Only about 48% of workers who leave their jobs and enter disability support systems return to work; 36% "retire" due to disability, and 16% die.[5]

The incidence and prevalence of disability suggested in the above statistics will continue to rise as medical breakthroughs help people live longer. The National Institute on Aging projects a 53% increase in the number of people in disability support systems and rehabilitation programs in the next three decades.[6] Given that this statistical outlook has existed for many years without substantial improvement, placement must become a serious concern of all vocational rehabilitation professionals.

Labor Markets as a Conceptual Framework

It is helpful to recognize that **placement occurs when a person is offered, and then accepts, a job**: an employer has to make a decision to select an applicant, and an applicant has to decide to accept the job offer. This type

of search is conducted in labor markets. Of course, in order to understand how placement occurs and to plan services that take advantage of how labor markets work, it is necessary to understand labor markets as a concept.

In essence, **labor markets are simply mechanisms to put the right persons in the right jobs**. Just as supermarkets exist to assist people in obtaining desired foods quickly and easily, **labor markets exist to help select the appropriate people for the appropriate jobs**. Note that **two decisions** must be made: (a) **to whom to offer a job**, and (b) **whether to accept a job offer**. Thus, **two decision makers** are necessary: (a) **employers** who select applicants, and (b) **applicants** who select employers. Employers create the demand for workers while applicants comprise the supply of workers available to fulfill the demand. Labor markets help employers and applicants manage their respective decisions.

If supermarkets provide the opportunity for persons to select food in exchange for money, what is exchanged in labor markets? One way of looking at this is to **view *decisions* as the products that employers and applicants desire to obtain from the labor market. Information is exchanged to make decisions**. The quality of decisions improves with the investment in information. However, obtaining information carries a cost, and **applicants and employers want to make the best decisions without bearing excessive costs**. Because employers use many sources to create an applicant pool, they incur many costs when recruiting and hiring workers. **Even though rehabilitation agencies, as one source in this pool, do not charge employers for placing an applicant, agencies still must show that they can reduce employer costs in other ways**.

Placement Models

There is considerable overlap in current placement models; the only major difference is one of perspective. One viewpoint focuses on the **role of counselors**. ***Selective placement*** denotes an approach in which **counselors actively persuade employers to provide opportunities to persons with disabilities. Counselors bear most of the responsibility** for organizing all needed services. The disabled person (the consumer) is usually not very active in the process leading up to employment, except as the recipient of services. A contrasting view is described as ***client-centered placement***. Under this model, **the counselor is nondirective and acts as a facilitator** or teacher who enables the consumer to select and pursue services and employment as independently as possible; **in client-centered placement, most of the outreach to employers is carried out by clients themselves**.

A second perspective for describing placement models is based on a **service delivery approach**. ***Competitive placement*** refers to a **train–place–follow-up process** that leads to employment. This approach reflects traditional vocational rehabilitation in which **most services are provided prior to employment**, usually in special, segregated settings designed for persons with disabilities. In contrast, ***supported placement*** uses a **place–train–follow-up** approach to service delivery. This model **provides most services in work establishments after employment is obtained**. These settings are integrated, including persons with disabilities among workers without disabilities. **A rehabilitation service provider brings services to consumers in the community rather than requiring them to travel to special facilities**.

Competitive and ***supported placement*** affect the supply side of labor markets in that they **are designed to enable disabled persons to compete with others for jobs**. Gilbride and Stensrud[7] suggest that a third perspective is necessary—one that has an impact on the *demand* side of labor markets. Such a model would actually **create jobs for persons with disabilities through active interventions initiated with businesses. The focus of change would be the work environment as opposed to persons with disabilities**. The **projects with industry (PWI) model** incorporates several aspects of this approach. PWIs are employer-rehabilitation partnership programs that seek mutual ways to fulfill organizational needs by providing employment for disabled persons. Gilbride and Stensrud[7] indicate how the Americans with Disabilities

Act (ADA) provides additional opportunities for promoting these demand-side models. Rehabilitation professionals can provide employers with valuable services for which businesses are willing to pay because they are required by the ADA.

All of these models have useful ingredients and all have made an impact on labor markets on behalf of disabled persons. It is now possible to envision a more complete model that carefully balances the attention of rehabilitation professionals across the supply *and* demand sides of labor markets.

Placement Services for Employers

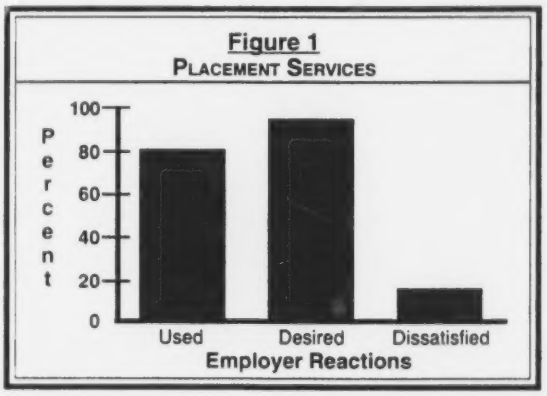
In any situation, **the agency must remember that it is not the sole provider of services for an employer**. Indeed, competition pervades all layers of labor markets. **Being able to help employers wisely manage costs provides the best opportunity for rehabilitation professionals to facilitate the employment of persons with disabilities. The challenge facing rehabilitation professionals is to optimize outcomes for disabled persons and employers at the same time**. With success, their role will become increasingly valuable to employers, disabled clients, and society as a whole.

Employers want to obtain productive workers through an efficient and effective hiring process. **Incentives that rehabilitation programs can offer employers include**:

- **Low-cost access to job candidates**
- **Applicants who are prescreened**
- **Follow-up support for long-term success**

Research confirms that these are important expectations that employers hold for rehabilitation programs.[8,9] This same research, however, indicates that **employers' expectations are not met completely**. In these studies, employers who were experienced users of rehabilitation services responded that more could have been done by rehabilitation programs to serve them. All efforts to serve employers should be explained in terms of how the above expectations can be met by the services provided. But it must not be forgotten that the chief reason for serving employers is to ensure that they hire the right person for any given job.

Figure 1 illustrates that **many employers did not receive desired services**, and that **almost one fourth of those who had received placement support were not entirely satisfied**. These employers were probably the best customers of rehabilitation services because many of them had hired more than one person with a disability through rehabilitation programs. It is apparent that **employers are not being served well enough in two important areas: the hiring process and the provision of follow-up support**.



How do we interpret these results for use in daily practice? First, all services provided to employers should be justified in one of two ways. **Service should be directed either toward helping the employer hire the right person or, once the person is hired, providing the appropriate follow-up**. The labor market model suggests that **the *place-train* or *place-train-maintain* supported employment models of service delivery make the most sense market-wise**.

Second, **the rehabilitation field, as a whole, is not providing follow-up support to the degree needed and desired by employers**. With the growth of supported employment, this expectation might be met to a greater degree than at any time before. Supported employment has also defined the **types of support** that can be included

in follow-up: **coworker instruction, crisis intervention, job modification, site accommodations,** and **identification and use of natural work site supports** (e.g., coworker mentors and transportation assistance). Any service that overcomes a job-related problem—even family counseling dealing with domestic problems that interfere with job success—should be offered. Visionary delivery approaches developed through supported employment should be extended to all types of placements. Employers do not distinguish between competitive and supported jobs. To them, all of their jobs need to be performed at the most profitable competitive rates possible.

Placement Services for Clients with Disabilities

Most people who come to vocational rehabilitation programs do so because they want to work.[10] Of course, there are those who are unmotivated to work and, regardless of what services are offered and provided, are not likely to be placed. Other persons will not be employed because they do not have the appropriate labor market skills.

Table 1 portrays the variety of behaviors that employers feel contribute to the success of a worker.[9] **These behaviors and skills include more than just the ability to complete job tasks in productive fashion.** In addition, Table 1 compares workers with disabilities in supported and competitive placement with a hypothetical average worker. (The workers in competitive placement had high potential and were assumed not to need supported employment.) **This average worker, by definition, is rated a "2" on a 3-point scale. For example, on productivity and work skills, supported workers are rated somewhat below competitive workers with disabilities who, in turn, are rated on a par with the average worker in these areas.** In spite of these lower ratings, **supported workers are rated overall as only slightly lower than the average worker, whereas competitively placed workers with disabilities are rated higher.**

Employers evidently value a variety of work skills and behaviors other than performance on job tasks. Better-than-average performance in other areas can compensate for less-than-average work skills. Employers rated supported workers highly in attendance, punctuality, and dependability. This suggests that a good performance in these areas can compensate for diminished productivity. A balance among these behaviors is required of a person to be a highly marketable candidate for placement.

Table 1
Comparison of Disabled Workers with Other Workers

Performance Category	*Average Worker*	*Supported Worker*	*Competitive Worker*
Social integration with coworkers during breaks and lunch	2.0	1.8	2.0
Social integration with coworkers during regular work hours	2.0	1.8	2.0
General appearance	2.0	2.0	2.1
Compatibility with supervisors	2.0	1.9	2.1
Compliance with instructions	2.0	1.8	2.1
Punctuality in arrival to and departure from work	2.0	2.3	2.4
Productivity	2.0	1.6	2.0
Safety/accident prevention	2.0	2.0	2.2
Dependability	2.0	2.2	2.4
Attendence	2.0	2.4	2.5
Work skills	2.0	1.6	2.0
Work habits	2.0	1.8	2.1
Work attitudes	2.0	1.8	2.1
Overall work performance	2.0	1.8	2.3

JOB-SEEKING SKILLS:

Besides work performance skills, employers indicated that **they value applicants who can demonstrate good job-seek-**

ing skills.[8] **Employers seem to use ability in this area to indicate work potential** if that cannot be measured directly. Thus, given this input from employers, rehabilitation professionals need to provide services to equip consumers with a variety of on-the-job skills and job-seeking ability. These are relatively independent and require different behaviors and knowledge.

WORK READINESS:

As consumers become more skillful, they increase their work readiness. Much effort has been devoted to defining the concept of work readiness and how to quantify it. However, readiness is a relative concept that can only be defined by the unique interaction between a person and employers in the labor market. **Theoretically, a person is work ready when he or she can do one job. However, the odds of finding one particular job are slim. The more jobs a person can be "ready" for, the more likely he or she will become employed**, although there is no optimal profile of work readiness that a consumer should have before placement is attempted. There are diminishing returns to improving readiness.

SKILL BUILDING:

Skill building should begin with evaluation and assessment to determine the disabled client's current functioning and knowledge. It should also be determined **how a person learns best** so that service delivery can be tailored to his or her unique needs. Knowing how to do this will also be useful when working with an employer to develop any necessary accommodations required by the ADA.

The Evaluation Process

If a person has a work history, **the evaluation process should begin with a transferability-of-skills analysis**.[11] This can be a short-cut to identifying previously developed skills that can be applied to other occupations. **Care must be taken to adjust the level of these skills on the basis of current functioning abilities**, which may have been modified due to the onset or profession of disability since the earlier work was performed.

Transferability analysis can be greatly facilitated by **computerized systems**. The results can be as useful as those from a complete vocational evaluation and are **more cost- and time-efficient**.[12] **Transferability analysis can also point to areas requiring more thorough assessment methods**. This also reduces the time and cost of an evaluation by eliminating assessment of functional areas that are already documented by the transferability analysis. Another useful feature of transferability analysis is its **potential to present a variety of future labor market possibilities to consumers based on different training or education strategies**. These "what if" scenarios can be very helpful in selecting service options that have the best payoff for meeting short- and long-range needs of consumers.

For persons without a work history, more traditional evaluation approaches must be applied to provide an opportunity to explore their potential in the labor market fully. A foremost principle of any evaluation is that **findings should be used to identify the full range of available labor market possibilities**. Findings should not be applied to limit options. **Whereas the labor market is designed to narrow the range of jobs for which a person can compete, the rehabilitation process should expand options so that consumers can pursue as many jobs as possible**, thus increasing their chances of finding an appropriate position.

The Job Placement Process

DEVELOPING A REHABILITATION PLAN:

The rehabilitation counselor should specify objectives at the outset of rehabilitation planning. This will facilitate placement by indicating the features of jobs that will meet consumer needs, such as income, hours, and location. These are general parameters that can be met by

many different types of jobs in many different industries. Of course, clients have other needs that should not be discounted; e.g., finding jobs that meet their interests, skills, and career ambitions. **Fulfilling these needs, however, depends on information that is not likely to be available early in the rehabilitation process. As consumers become more knowledgeable of labor market opportunities, they can make better judgments regarding these other needs.** Again, the rehabilitation process should work to expand horizons, because the labor market will narrow options to the one job a consumer will eventually obtain.

FINANCIAL NEEDS OF THE CLIENT:

Framing objectives in terms of income needs is recommended because **financial needs are frequently compelling. Many clients risk losing disability income and medical benefits if they become employed.** A critical decision involves **determining whether or not work will pay off**: will the income such workers earn offset the loss of disability and medical benefits as well as the costs associated with working (e.g., transportation, clothing, and food expenses)? Perhaps many consumers become unmotivated when they realize that work may not be worthwhile because the jobs available to them do not improve their finances. Also, **by determining their income and benefit needs, and by estimating the income they could earn given their current capabilities** (i.e., their current value in the labor market), **a benchmark is established to determine if they can obtain suitable jobs or if additional training, education, and skill building will be needed.** A strong incentive to motivate a client is to show him or her how **participation in rehabilitation activities can increase his or her income potential.** Although there are indeed other reasons people desire to work besides salary, receiving an income is an essential need that predominates over others. **Needs associated with income generally must be met before needs such as personal interests and achieving social status are fulfilled.**

ASSESSING AND TEACHING JOB SKILLS:

Frequently, after standards are set and the evaluation of the range of labor market skills is identified, it is **possible to proceed in assessing and teaching job skills in preparation for placement. There are three reasons, however, why this typical phase of the rehabilitation program can be circumvented.** First, **most employers expect to provide orientation**—and even training—to new employees if they have met basic entry requirements. They will do this regardless of the prior training employees have had. **Rehabilitation training programs, though they provide valuable skills, often cannot give the person the specific skills unique to a particular employer; such skills must be learned on the job.** Second, experience with supported employment documents **the willingness of employers to allow rehabilitation training resources to be used on the job.** On-the-job-training (OJT) has been shown to be a very powerful training technique. Third, **more formal approaches to training are not as successful.** Studies have documented that over half of all placements after training are not related to what was trained previously.[13]

Completing a training program, however, does appear to be valuable to employers, even though what was learned may not necessarily matter. Having completed a training program **indicates that a person can learn successfully and is willing to persist** until a job is complete. Therefore, **training should be considered in those cases in which it can substantially increase the odds that someone may become employed.** Training is also important if only certain kinds of jobs can provide for the income needs of a consumer.

Training should take place in a rehabilitation setting rather than on the job, for several reasons. First, optimal performance usually does not depend on transfer of learning from the learning environment to the criterion environment in which the learned skills are to be performed. OJT is obviously superior in this regard because no transfer is required. If OJT is not possible, community-

based training programs such as those found in adult or vocational education programs, community and four-year colleges, and technical/business institutes should be considered. Also, these programs usually have greater resources to keep training standards in line with current labor market demands that are often difficult for disability-specific programs to achieve.

THE JOB SEARCH:

Job-seeking skills instruction can begin at any point in the process, but it **typically commences when training or other skill-building activities are coming to an end**. There are many commercially available packages for facilitating these skills. Group instruction is possible, but individual needs must be considered. Some consumers will be able to learn on their own by using self-study guides, while others will require intensive one-on-one tutoring.

Different labor markets require different search skills. Accordingly, **job-search skills instruction must be tailored for labor markets**. Instructional packages typically do not account for such specification.

The job-seeking process should be initiated by the development of formal placement plans that document the full set of objectives to be achieved including income, location, and types of jobs desired. Companies to be contacted should be listed, including which contacts are to be made by the counselor or placement specialist. The extent of contacts, as well as the time frame in which they are to be made, should be indicated to ensure that accountability is incorporated into the process.

Indeed, the job search should be an intensive process. In addition to reinforcing the importance of job search activities, **specifying responsibilities and due dates**, while requiring signatures of both the job searcher and professional, **symbolizes the rehabilitation plan as a contract between counselor and client**. The plan should specify activities for only several weeks and **should include check points for the client and counselor to review progress, share information, and make revisions in the plan based on new information. The search should be broad and the plan flexible to take full advantage of new labor market knowledge**. It is not unusual for original vocational objectives to be modified as a result of job searching that reveals new labor market opportunities that had not been anticipated. **If a job offer is obtained, the original objectives pertaining to income, location, and other needs can be used as a standard to see if the offer is adequate**. How well one job offer matches the consumer's original objectives can help him or her decide whether or not to accept the job.

The job search can be difficult in terms of the time and effort required. It is also **a potentially threatening process**, because a job seeker faces numerous personal evaluations that more often than not result in rejection; this can seriously diminish motivation to continue. Clarifying expectations based on typical labor market experiences is one way of dealing with this threat. Job searchers need to recognize that, on average, **many contacts are needed to obtain one offer**. Rejections are to be expected. **But each rejection reveals new information to be used in further searching and also brings the person one step closer to an actual offer**. Searchers must realize that this is how labor markets work and that they are not to take rejection personally.

FOLLOW-UP SERVICES:

Once a placement occurs, **the counselor has the opportunity to serve the client and employer simultaneously through providing follow-up services**. A contact schedule should be set up in advance with both parties, particularly if the counselor had a prior relationship with the employer. If the consumer found the job on his or her own, the counselor must get his or her permission before following-up with the employer. Scheduled contacts can usually be made by telephone, which saves everyone's time.

The counselor also must be available to handle emergencies or unforeseen circumstances for which the person or employer requests help. **The ability to respond to requests from both parties separates the rehabilitation counselor from other employment resources available to employers**. Being able to assist with follow-up over a reasonable period of time will do much to ensure repeat placements.

DEVELOPING A PLAN FOR CAREER DEVELOPMENT:

One final placement function is to **work with the client to develop a plan for career development**. As with the placement plan, **this plan should specify career objectives and action steps for achieving them**. Obviously, the rehabilitation counselor will have less responsibility in fulfilling this plan than the placement plan. The major responsibility rests with the client, and, to some extent, with the employer. However, any assistance given by the counselor (e.g., pointing out to the employer how additional accommodations can be made) is desirable.

Recommendations for Placement Practice from the Research Literature

In an extensive review of the literature, Vandergoot[14] described **research findings from the previous two decades that possess implications for placement practice**. These findings suggest ways to implement services as well as how programs can be organized and administered. Briefly, these major findings are:

- **Placement should be made an explicit priority** for service staff. Top management should communicate this by setting performance requirements, establishing placement target goals, and rewarding staff on the basis of their contributions to the placement effort.
- **Formal evaluation strategies**, such as paper-and-pencil testing, **should be superseded by techniques that reflect principles of situational assessment and evaluate persons on real tasks, in real environments, and in real time**.
- **Vocational goals set by the disabled client should be broad at the outset** to avoid pigeon-holing the client into one job type. The labor market is designed to narrow a person's search to one job. **The rehabilitation process should not do that prematurely** and deprive a consumer of the feedback obtained through interaction with the labor market.
- **Place-train approaches are more congruent with how labor markets function**. Employers expect to train new job incumbents, and training is more successful when transfer of knowledge is minimized.
- **Employers have indicated a need for assistance after a placement beyond what rehabilitation professionals can give them**. Given the limited resources available to vocational rehabilitation systems, **placement success is more likely if more energy is spent preparing a person to be successful *after* placement than investing in training before placement**. This should apply to all clients rather than solely to those in supported employment.
- **Job development should occur in the context of building employer partnerships**. It should not be a one-shot enterprise to secure a job for a specific consumer, especially if the employer is unknown. Placing a consumer at an unfamiliar worksite can result in a good match only by chance and does not reinforce the notion that rehabilitation professionals are labor market experts. **Job development should focus on referring persons to an employer only if there is a good likelihood that they offer what the employer needs and that the employer offers what they need**. These referrals are needed especially by persons who do not have the resources to participate in independent job-search activities.
- **Formal placement plans that detail responsibilities** of both the disabled client and the rehabilitation professional are useful for improving placement performance. These plans guide and organize the efforts of both parties and **give an edge to participants in a rehabilitation program, because the search processes used by others tend to be haphazard**. When plans are revised on a regular basis, consumers have opportunities to apply what they learn from their searching and redirect their efforts to take advantage of new opportunities.

The Use of Marketing Techniques

In the past, the rehabilitation field has explored how marketing can be used to develop more productive relationships with employers, mainly through job development and various media appeals. However, **broader applications of marketing are possible** and have the potential to benefit rehabilitation programs in many more ways. **Appropriate use of marketing requires an organization to systematically identify its purposes based on the needs of its customers. A marketing-conscious organization is able to state its mission and goals clearly, develop services that effectively achieve these purposes, and communicate them to the varied audiences on which it depends.**

Applying marketing strategies is particularly useful with employers. After all, marketing is a business tool. Business people understand the value of marketing, and **the language of marketing can serve as a common denominator between employers and rehabilitation professionals. Describing rehabilitation programs to employers in marketing terms enables them to understand how rehabilitation programs can assist them with their labor market needs.** The fact that both rehabilitation and business depend on labor markets for a significant portion of their success reinforces the idea that using marketing strategies within a labor market context is conceptually sound. Now, with the passage of the ADA, employers have a second need for assistance: **rehabilitation professionals can market themselves as teachers who can provide assistance in complying with ADA regulations.**

Marketing to employers can be defined as **an ongoing approach that enables vocational rehabilitation agencies to identify employer needs, refocus resources and management structures, and improve services to people with disabilities and employers who satisfy these needs.** The goal of marketing to employers is to **establish long-term partnerships that will lead to more and better job opportunities for those with disabilities.** Rehabilitation agencies that adopt a marketing philosophy understand that they must serve several customers. Included are persons with disabilities and employers who will eventually hire many of these persons. Referral sources, vendors, and professionals such as physicians are examples of clients with whom the agency needs to develop mutually satisfying relationships. Therefore, **a rehabilitation agency guided by a marketing philosophy will move from an organizational focus to a customer focus.** It will frame its goals in term of the needs of its major audiences. Moreover, using marketing approaches can redefine problems faced by agencies and suggest new ways of solving them.

Specifically, a marketing-conscious agency:

- Recognizes that **it has value only insofar as it adequately meets the needs of its customers**
- **Holds itself responsible for its failures and does not blame its customers** (i.e., "unmotivated clients" and "prejudiced" or "ignorant" employers)
- **Conducts ongoing research** to identify the needs of important customers, and collects data to evaluate how well these needs are met
- Uses public relations strategies to communicate its mission and value to customers.
- **Requires that all staff understand how their functions contribute to marketing** because all staff should perform in ways that meet the needs of employers and people with disabilities
- **Develops a marketing strategy for each of its important customer groups**
- **Provides services that enable the agency to meet needs in a way that competing agencies cannot**

Components of the Marketing Process

The three components of marketing are: (1) **Environmental assessment; (2) strategic planning; and (3) implementation.** Although described separately here, these components are interdependent. Together, they comprise the marketing process and form the core of a philosophy and concern for customers which must permeate the entire agency.

ENVIRONMENTAL ASSESSMENT:

Environmental assessment is a continuous process conducted to reveal significant or unexpected changes in the internal and external environments that might affect the agency. Environmental assessment includes **identifying opportunities** (or benefits) **and threats** (or risks) **presented by environmental forces that influence the ability of an organization to attain its goals**. The purpose of this assessment is to help an organization adjust to changing customer needs.

To build partnerships with employers that result in job opportunities for persons with disabilities, **agency personnel need to be aware of how employers currently meet their labor market needs**. They also should know **employers' perceived risks and benefits** for being partners with a vocational rehabilitation agency as compared with other sources of job applicants.

There are **two ways that environmental assessments can be approached**—through **environmental "scans"** and **more formal marketing research**. **An environmental scan is an informal, ongoing process to identify and act proactively to events in the environment**. As applied to developing a marketing strategy for employers, an environmental scan might focus on **identifying and monitoring external factors that impact the agency's ability to supply sufficient, appropriate jobs for clients**. Factors include local and national economic, political, and social forces. Information about competitors, technological changes, and clients may also be relevant. Agency personnel might want to keep a close watch on referral sources, labor market trends, and the changing nature of the demographic composition of the local population.

Similar to scanning, **marketing research gathers data on environmental forces**. **Environmental scanning, however, is used to raise questions, whereas marketing research is designed to provide answers**. As a formal process, it **follows a problem-solving structure using quantitative methods** appropriate to the question at hand. It plays a critical role in understanding the behavior of outside influences and in planning customer-related activities; and it **ranges from conducting simple, one-time analyses of easy-to-access documents, to complex, long-term, or repetitive experiments**. It can rely on low-cost techniques or involve considerable expense.

STRATEGIC PLANNING:

Strategic planning has been heralded as the key to successful management. In fact, managers in the public and nonprofit sectors have been encouraged to adopt this management style. When executed properly, **strategic planning creates a vision of the agency's mission** that all managers and staff can personalize. Furthermore, staff can use this vision to guide their activities on a daily basis.

The key ingredients to successful strategic planning are participation, communication, and action. **Representatives from all departments and units should work together to formulate this overall agency vision**. Writing the plan, however, cannot be viewed as an end in itself. In fact, writing the plan is the easy part. Too often, having this document in place seems sufficient. The true value of the written plan will be realized when managers and other staff use it to guide what they do.

No matter how well prepared and reported, a strategic plan will not work until **its values and content are communicated and enforced throughout the agency**. The agency's key managers collectively represent the most effective channel of communication. A constructive, consistent, personal involvement by managers will assure staff at all levels that there is a sense of purpose within the agency.

When strategic planning is first implemented, **the agency should begin by clarifying its central mission**, using information gained from environmental assessments. Next, the agency should follow a sequence of interdependent and ongoing steps that enable it to be flexible and responsive to its clients:

1. **Establish the agency's mission**
2. **Develop the goals and objectives of each department**
3. **Identify the segments of each target audience the agency serves**

4. **Implement a coordinated action plan to deliver the products and services to the target clients according to specified income and expense budgets**
5. **Promote the agency, its products, and services, in a way which clarifies its image to clients and informs them of how the agency will meet their needs**
6. **Evaluate progress made toward accomplishing goals and objectives, and use the results to revise the plan**

This planning process is central to the marketing model. Vocational rehabilitation agencies already implement most of these steps, but what may be lacking is a coordinated approach that links each of these steps through deliberate staff involvement.

A final consideration must be given to the marketing budget. The marketing department should have its own budget. **Budget setting is concluded after action plans are in place, because an adequate budget can be prepared only after all the required activities and available resources have been identified.**

IMPLEMENTING MARKETING PLANS:

The implementation of marketing occurs daily after the strategic plan is finished. **Marketing functions must be integrated and coordinated with all departments in the agency so that the client-oriented aspects of the marketing plan pervade the agency.**

It is essential that the agency director clarify that the primary purpose of marketing is to help the agency and its departments achieve goals and objectives based on client needs. All marketing functions must be viewed as contributors to independence and employment opportunities for persons with disabilities. **However, marketing will not supercede services as the major activity of the agency; services are expected to become more effective because of the support from marketing.**

Integration of marketing can be encouraged by **providing opportunities for marketing and service staff to work together on joint projects.** For example, marketing staff would benefit greatly from the input of staff throughout the agency. Staff workers who are asked to be involved in environmental scanning will recognize the value of such information. To maximize input, **staff should be urged to work with marketing personnel to see how their goals and objectives could be enhanced with marketing input.** If more supported employment placements are needed, for instance, job development and marketing staff could investigate which employers would be most likely to provide such placements.

Many organizations undertake public relations without implementing the other marketing functions. Although this type of outreach is key to achieving objectives, it must be developed within the context of a *total* marketing effort. All research and planning activities support the effort to market the services of the agency. Too often, marketing is perceived as simply public relations work; e.g., preparing brochures and the like.

Promotions are intended to help clients familiarize themselves with the agency's resources to meet their needs. For example, the agency may choose a promotional strategy to help employers understand the value of hiring persons with disabilities. There are many different ways to accomplish such a promotion: advertising, public relations, sales, and the use of various media to communicate a message.

The ability to communicate ultimately leads to successful promotions. **To communicate effectively, the following principles should be applied:**

- **Know the needs of clients**
- **Know what clients are currently doing relative to their needs**
- **Be able to specify the outcomes that the targeted client should achieve**
- **Be prepared to respond to clients' requests for services**
- **Design and implement a feedback system that identifies the changes achieved by clients**

The message should contain a **description of the positive consequences that will occur if the client "buys" the services of the agency**. For example, employers are likely to be receptive to a communication if it contains a description of the placement service and its benefits, including how it can reduce their hiring costs.

There are many different ways of communicating. **Personal contacts ("sales") are useful with business professionals**. Job developers and placement specialists are the agency's primary targets of sales techniques. **Advertising should be used as well**. A combination of paid and public service advertising may be needed, because most employers might not hear public service messages when they are announced.

Any contact with the public, and particularly with target audiences, must communicate the purpose and professionalism of the agency. All communications should indicate how prospective employers' needs can be met and should convey a highly credible image of the agency.

MARKET RESEARCH:

One of the most important marketing functions involves **formal and informal research to collect pertinent information**. Discussions should be held with job developers and placement specialists to assess impressions of employers with high and low potential for hiring people with disabilities. Case files should be reviewed for patterns of jobs in which persons are placed. A study of these patterns could be used to evaluate whether employers recruited by the agency are compatible with agency and consumer goals.

More formal research secures new or more up-to-date information. For example, employers who have hired consumers could be surveyed to determine what future hiring expectations they project, and could provide feedback useful for designing new services. **Information about past and current placement performance and the level of employers' satisfaction with these efforts serve as an excellent benchmark for specifying goals and objectives for coming years**.

In order to determine their value before being widely implemented, **new services should be pilot-tested with samples of potential clients**. For instance, in testing a new strategy to encourage employers to use the agency's placement services, consumers, employers, and staff could be interviewed for suggested improvements. **Knowledge gained from pilot testing typically offsets the research costs by revealing more effective and efficient applications of the agency's services**.

Marketing research also aids in the development of a successful promotional strategy. After an agency has decided what message to send to employers, it might wish to convene an employer focus group to gather ideas regarding the best medium and format for delivering the strategy and its message.

Summary

Understanding how labor markets work equips vocational rehabilitation counselors with a framework for designing services and program management strategies sensitive to the needs of persons with disabilities *and* employers. Applying this framework firmly embeds placement activities within the mission of any rehabilitation agency. Complementing placement services with comprehensive marketing strategies enhances the resources directed at finding employment opportunities for persons with disabilities.

Marketing, as used here, is a philosophy as well as a process. As a philosophy, it is solidly within the rehabilitation tradition of emphasizing the needs of persons with disabilities. As a process, it coordinates up-to-date techniques to ensure efficient and effective approaches to meeting those needs.

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Questions Based on this Lesson

37. As a rule, which of the following do vocational agencies *not* offer to employers?

    A. Prescreened applicants
    B. Lower-salaried applicants
    C. Follow-up support
    D. Low-cost access to applicants

38. Which of the following suggestions for placement practices is *not* advocated by the author?

    A. Evaluations that reflect actual situational issues should be used instead of paper-and-pencil testing
    B. Job development should occur in the context of building employer partnerships
    C. Job training should be considered in cases where it will substantially increase the odds of employment
    D. Clients should always have a specific vocational goal in mind

39. The advantage of disabled workers in *competitive* placement over those in *supported* placement is least noticeable regarding:

    A. Work skills
    B. Dependability
    C. General appearance
    D. Compliance with instructions

40. Competitive placement:

    A. Refers to a train–place–follow-up process for employment
    B. Is a placement model in which the counselor selects employment and services for the client
    C. Denotes an approach in which counselors actively persuade employers to provide employment for clients with disabilities
    D. Primarily affects the demand side of labor markets

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 11

Empowerment of Older Disabled Persons: A Rehabilitation Imperative

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Editor's Note

As the percentage of those older than 65 continues to increase rapidly, the problems that the elderly face are becoming more evident to the rehabilitation profession. As a person ages, he or she experiences many forms of loss, including deaths of friends and relatives, retirement and the absence of motivating employment, decreasing financial security, and decline in health and physical capability. Elderly persons often suffer from depression and a feeling of worthlessness, and it is essential for rehabilitation professionals to understand and address effectively the unique obstacles faced by this population.

Dr. Myers presents several rehabilitation strategies that aim to increase life satisfaction among the elderly. In addition, she analyzes what she perceives to be dangerous trends in rehabilitation, such as devaluation of the elderly, lack of interest in their problems, and a lack of opportunity for effective treatment. Policies of empowerment by which the elderly can become more able to influence people and organizations that affect their lives, she proposes, should be implemented to counteract these trends.

The "social breakdown syndrome," common in many elderly clients, leads to low self-esteem, an impaired sense of self-efficacy, and an external locus of control—all of which result in a lack of perceived personal power. This lesson presents four models of rehabilitation specifically applicable to an older population: the moral model, the enlightenment model, the medical model, and the compensatory model. Each model has unique benefits and drawbacks, yet each shares the goal of counteracting the conditions explained by the social breakdown system, including negative adjustment and decline in later life.

It is important that rehabilitation counselors remain cognizant of the problems and treatments outlined in this lesson when counseling elderly clients, so that the difficult and often tragic situations that arise in later life can be successfully considered, recognized, and treated.

Introduction

The percentage of persons in the population older than 65 years of age has increased from 4% in 1900 to almost 13% in 1992 and is expected to increase to 20% by the year 2050.[1] Since 1900, the **average lifespan** in the United States **has increased from 47 years to almost 84 years**, with additional increases projected over the next 50 years. **Improvements in medicine**, which allow persons with disabilities to continue to function independently, **represent a major reason for these increases**. Considered as a group, **older persons are known to experience the greatest amount and variety of disabling conditions and therefore require more care than younger persons**. For example, older persons account for 36% of total personal health care expenditures, with an average of 4 times more dollars spent for each person older than 65 years of age than for each person younger than 65. Older persons average more contact with physicians and account for 34% of all hospital stays and 45% of all days of care in hospitals.[1]

Of particular interest to rehabilitation professionals is the fact that one third of all functionally disabled persons are at least 65 years of age.[2] As the mandatory retirement age increases, many of these persons will choose to remain in the labor market; others will **require assistance to continue living independently in the community**. It is no longer considered appropriate to deny the benefits of rehabilitation services and the rehabilitation philosophy to persons who have reached an arbitrary age. **Older persons with disabilities are increasingly seeking the services of rehabilitation practitioners, both for vocational services and for independent living.** Therefore, it is essential that these practitioners understand the dynamics of later life and the effects of the interaction of aging and disability. Furthermore, **it is important for rehabilitationists to include in their repertoire of skills specific strategies for working effectively with older disabled clients**.

Aging and Disability

Among the more than 26,000,000 older Americans, approximately **86% experience at least one chronic physical condition that limits their daily living activities.**[3] The most common impairments include arthritis (47%), hypertension (37%), hearing impairments (32%), heart disease (29%), orthopedic impairments (17%), cataracts (15%), sinusitis (15%), diabetes (9%), and tinnitus—the sensation of noises in one or both ears (9%). Heart disease, stroke, and cancer, the three leading causes of death among older persons, result in progressive physical disabilities in later life. Given the high incidence of chronic disabling conditions, it is not surprising that **older persons take an average of six different drugs per day**, including prescription and over-the-counter medications.[4]

The interaction, or interdependence, between physical and mental health conditions tends to increase significantly with advancing age.[5] Not only are older persons more likely than younger persons to experience multiple disabling conditions simultaneously, but they also experience **substantial comorbidity of physical and mental health problems.**[6] In spite of these conditions, most older people are independent functionally, and almost 80% report their health to be good or excellent.[7] However, 23% of older persons have health-related difficulties with one or more personal care and home management activities, and more than **80% of older persons in nursing homes**—4%–5% of the older population—**require assistance with activities of daily living.**[8]

Psychosocial Aspects of Aging

Psychologically and socially, the older population is extremely **heterogeneous**. Most older persons adapt successfully to the challenges of later life, but some do not. **Persons who adjust successfully to the aging process are those who experience a high sense of life satisfaction**, defined as a sense of high morale or a feeling of well-being. **Factors that correlate with life satisfac-**

tion include good health (usually the top-rated factor), **adequate income** (usually rated second), **employment**, and **social support**. Researchers who study older persons have attempted to define common aspects of aging and develop theories to predict life satisfaction and successful adaptation in later life.

Theories of Aging and Late-Life Development

Psychological theories that define how life satisfaction is achieved as people age **include "disengagement," "activity," and "continuity" theories.**

The disengagement theory proposes that as people grow older, they withdraw from society and relinquish social roles. At the same time, society withdraws from aging persons in a mutually desired process, which results in little disruption of the broader society when an aging person dies.

The activity theory, which is more consistent with the American work ethic, posits a different scenario: it **suggests people will age successfully if they are able to replace the roles** (such as worker or spouse) **that are lost as they grow older.**

The continuity theory applies yet another perspective; it hypothesizes that **people are able to age successfully if they maintain values of mid-life and continue their same basic activity structure into old age.**

From a rehabilitation perspective, all three views may be applicable in the appropriate context. Some older persons will be happiest if they continue working; others will achieve life satisfaction through other means, such as replacing work roles with volunteer activities, community service involvement, or grandparenting.

Lifespan developmental theories also provide some insights into the behavior of older people, most notably the theory developed by **Erikson,**[9] who proposed that persons progress through a series of **eight sequential developmental stages, each marked by a central psychosocial crisis that must be resolved successfully in order to resolve successive stages. The central task of old age is to resolve the crisis of ego integrity versus despair.** Older persons commonly reflect on their lives in an attempt to discover or validate a sense of meaning and purpose. The outcome of this review process may range from a sense of meaning and purpose—that the life one lived is the best one could have lived (integrity), to a sense of regret that life was not lived differently. **Integrity prepares the older person to live the remainder of his or her life in relative psychological comfort, rather than in despair or depression.**

Late-Life Transitions

As people age, their ability to cope successfully with life changes and transitions may be affected. **Those who coped successfully throughout their adult life may find themselves less able to cope with the transitions of aging, such as retirement, adjustment to losses, and grandparenthood.**

Retirement is a psychosocial transition, which may be viewed similarly to a job loss at any point in a person's life. Although it may be expected or even anticipated, **reactions to retirement are negative in almost half of retirees.**[10] Jobs provide access to social net-works, social status, productive ways to use one's time, and a source of income. The loss of these benefits is equally significant regardless of the time in life at which they occur.[11] On the other hand, **the retirement transition can be a positive experience, allowing the older person the freedom to choose his or her own lifestyle and activities.**

Many of the transitions of later life result in, or are the result of, losses. Some of the major losses older persons may experience include **loss of work** as a result of retirement, **loss of a spouse** through death or divorce, **declining health, reduced income, loss of social supports** through death and geographic moves, and **loss of social status** as a result of being older. **Each loss requires a grieving process that eventually should result in**

resolution and acceptance of the loss. Unfortunately, older persons are likely to experience multiple losses before they have adequate time to grieve each one. As a consequence, they are at risk for experiencing "bereavement overload," similar to stimulus overload, in which they are unable to react and may become depressed and immobilized.

Not all of the transitions of later life are negative or undesirable. Some, such as the chance to decide how to spend one's time or the transition to grandparenthood, may be positive transitions. Coping and adjustment still may be required; however, the possibility of successful outcomes as a result of these types of transitions is very positive. Although they may be upsetting at the outset, most older persons adjust to late-life changes.

When older persons fail to grieve losses successfully, or fail to adjust to the changes that accompany the aging process, **they are at risk for developing a variety of physical as well as emotional problems**. Older persons unfortunately often experience multiple problems and stresses at a time when their resources to cope are declining.[12] **Social withdrawal and isolation**, common reactions to changing social support networks, **can exacerbate existing problems and complicate the rehabilitation process**.

Rehabilitation and Aging

Although older persons experience many common life circumstances, their reactions are unique and personal. As Kemp[5] noted,

> **Psychosocial factors are some of the most limiting causes of handicap among disabled persons, and it is possible that older people are even more handicapped by these than younger persons.** Regardless of how much effort is devoted to correcting 'mental health problems' surrounding rehabilitation of older persons, **ultimate improvement must come from also addressing the psychosocial factors adding to problems that lie outside the older person's control**.

Kemp identified **three factors that affect the process of rehabilitation in older persons**. The first, which he considered to be the most important, is **devaluation**. As is well known in rehabilitation, **disabled clients often are viewed as inferior** (or less worthwhile) than clients who do not have disabilities. **Persons who are both old and disabled experience a situation described as "double jeopardy": being devalued for multiple reasons.** If they are also a member of a minority ethnic group, a woman, or, in some situations, widowed or single, they may experience additional discrimination. **Practitioners who ascribe to these prevalent negative attitudes may unconsciously avoid working with older clients, fail to accept these clients' concerns as important, spend less time with them, and consider them to be unable or unwilling to change.**[6] Devalued groups characteristically internalize prevalent societal values and beliefs; therefore, **older persons are inclined to internalize the negative perceptions of others**. As a result, **they may experience a decline in their sense of self-esteem and feelings of self-worth**.

The second psychosocial factor affecting the rehabilitation process and outcome is a **general lack of interest in the problems of older persons combined with pervasive negative attitudes toward older people**.[5] The phenomenon of **ageism**, similar to racism and sexism, explains the negative, stereotypical views in which elderly persons are considered to be unattractive, unhealthy, unproductive, depressed, and unlikable. Unfortunately, **such beliefs tend to discourage service providers from working with older people**, thereby viewing their complaints and concerns as "normal" aspects of aging rather than treatable and curable phenomena. Wright's description of "spread," the tendency to attribute multiple characteristics to an individual based on one salient aspect (e.g., a disability or the appearance of being elderly), is relevant in this context.[13]

The third major psychosocial obstacle is **lack of opportunity**, reflected in underservice of older persons in

rehabilitation programs.[5] In 1980, less than 5% of all rehabilitation clients in the state-federal United States system were older than 65 years of age. This underrepresentation reflects both negative attitudes and the orientation of the rehabilitation system to full-time employment as a rehabilitation outcome. **Older persons are viewed as poor candidates for this vocational objective.**[14] Also, **feelings of vulnerability and inferiority among older disabled clients make them less able to be assertive with care providers to obtain the services they require.** Both external and internal factors combine to create needs for empowerment if rehabilitation programs for older disabled clients are to be effective.

Empowerment—External and Internal Perspectives

Empowerment refers to the process by which people become more able to influence the people and organizations that affect their lives.[15] This process may be viewed from two perspectives, from those external to the individual and from those internal. Each perspective results in a different approach to rehabilitation interventions and the implementation of different models of helping. The choice of interventions and models depends on the characteristics of the setting and the individuals to be helped.

The traditional approach to rehabilitation views disability from an individualistic perspective, defining the **responsibility for overcoming handicaps as belonging to the person with a disability**. More **recent approaches view society as responsible** for eliminating barriers that inhibit optimal adjustment of persons with disabilities. **External perspectives place the locus of responsibility for change on service providers and institutions,** whereas **internal approaches place the responsibility for change on individuals**. Although both approaches are necessary, **internal perspectives are especially important** as an integral component of personal empowerment in older disabled persons, because the realities of later life may contribute to changes in perceived self-efficacy.

Bandura[16] proposed the concept of self-efficacy as an explanation of behavior and behavior change. People's expectations or beliefs about their ability to behave in a certain way influence their thought patterns, actions, and emotions. People tend to avoid activities they believe exceed their coping abilities and undertake those they feel capable of handling. Persons with a high sense of self-efficacy experience a high internal locus of control, attempt behaviors, continue them over time, and expend effort toward achieving what they want or need.

Persons with low self-efficacy expectations have an external locus of control, believing that the circumstances of their lives are not in their control. They may have serious doubts about their ability to succeed even in minor activities, and are likely to give up completely when faced with obstacles. Bandura[16] noted that the "inability to influence events and social conditions that significantly affect one's life can give rise to feelings of futility and despondency." **People may give up for one of two reasons: they may doubt their ability or believe their efforts will be ineffective due to the negative attitudes of others or unresponsive—even punitive—environments.**

Social Breakdown Syndrome

The interaction of both internal and external factors as they affect older persons with disabilities is described in a model known as the **social breakdown syndrome**. This syndrome **incorporates a systems approach to explain negative adjustment and decline in later life**.[17] It describes the relationship between social input and self-concept, which results in a negative, self-perpetuating spiral of decreased psychological and physical functioning. **Even persons who were relatively independent throughout their lives are susceptible to social breakdowns at some point in later life, because many of the changes and losses of later life (loss of health, spouse,**

income, and friends) are beyond a person's direct control.

In the first stage of social breakdown, older persons have a precondition of susceptibility. This may be caused, for example, by doubts about one's identity and capabilities as a result of advanced age, retirement, or declining health. **Negative evaluations of older persons, as well as negative attitudes toward persons with disabilities**, are **contributing factors** that help set the stage for social breakdown.

The second stage of this syndrome is characterized by a process of **labeling the older person as incompetent or less capable than in their younger and/or nondisabled years**. The source of this labeling may be society in general, or it may derive from those individuals with whom the older person interacts—**care providers, family, friends, or employers**.

In the third stage, the older person is inducted into the "sick role." Freedom from work and responsibilities and time-out from dysfunctional relationships are among the benefits. The sick role is a dependent position that leads to secondary gains for many younger persons. However, for older persons, the role is not temporary and leads to the atrophy of previously held independent living skills.

In the **fourth stage** of social breakdown, **the older person internalizes a view of himself or herself as incompetent or inadequate. Impaired self-efficacy and low self-worth create a sense of vulnerability, which begins the cycle again at the first stage. As the cycle perpetuates, the older person increasingly is less able to function. Feelings of depression, hopelessness, and learned helplessness perpetuate the cycle.**

Social breakdown can be delayed, arrested, or even reversed with positive input at any point in the cycle. Techniques for empowerment are a primary means of preventing or alleviating social breakdown.

Empowerment and Models of Helping

Empowerment is not a panacea for all problems. In fact, in some instances—such as in cases where adherence to a medical regimen is required—it may even be counterproductive. Determination of the level of empowerment necessitated in a rehabilitation context can be facilitated by looking at where the responsibility lies for the problem and the solution.

Brickman and colleagues[18] developed a typology of helping based on the attribution of responsibility for problems and their solutions. **Responsibility for problems refers to who is to blame for an event or condition; responsibility for solutions refers to who is in control of future events.** When juxtaposed in grid format (i.e., responsibility for problems versus responsibility for solutions), four possible models of helping emerge, each of which is effective in different situations.

MORAL MODEL:

The moral model is applicable when clients are seen as being responsible for their problems as well as the solutions to them. If they are to take action to resolve their concerns, **they must be motivated in the direction of self-help**. The individualistic model of disability promotes the necessity of overcoming handicaps through personal effort. Older persons are viewed as needing to adjust to the circumstances of later life, or as needing to "gracefully surrender the things of youth."

ENLIGHTENMENT MODEL:

The enlightenment model views clients as responsible for their problems but not responsible for the solutions to those problems. They are viewed as being either unwilling or unable to provide their own solutions. Therefore, they **require outside intervention to assist them in achieving self-discipline**. Some of the most successful treatment programs for alcohol and substance abuse, such as Alcoholics Anonymous, operate on the enlightenment model.

MEDICAL MODEL:

In the medical model, persons are viewed as requiring treatment but are deemed not responsible either for their condition or for the solution to their problems. Here, powerful others ("experts") diagnose and prescribe treatment. **With this model, individual empowerment is counterproductive and may lead to conflicts between clients and their service providers. People must submit to treatment regimens for problems they did not cause and cannot resolve.**

COMPENSATORY MODEL:

The compensatory model views clients as not responsible for their problems but responsible for the solutions to their problems. They must be empowered to take action. Older disabled persons may be viewed as being limited by societal perceptions and beliefs. Therefore, they require empowerment to help them function independently and to change the attitudes and beliefs that restrict their activities.

Both the medical and enlightenment models can lead to dependency, because others are considered to be responsible for providing solutions. **The compensatory model can lead to hostility and alienation because persons are seen as needing to solve problems that were not of their making.** This model also offers the possibility of persons being credited for their solutions while not being blamed for their problems, which may contribute to a sense of self-efficacy. **Empowerment**, a process of enhancing the possibilities for persons to control their own lives, **is the most appropriate strategy for providing help within the compensatory model. Empowerment is a nondeficit model in which persons are seen as possessing strengths that can be mobilized in their own behalf**. Eligibility standards for services that require clients to demonstrate a weakness or deficit to obtain help would be antithetical to this model. Although these standards are common in most social programs, they are less common in service programs under the Older Americans Act.

Helping models depend on the needs of the setting as well as the client. **Severely dysfunctional clients or groups may require a medical model**, at least in the initial stages of rehabilitation, prior to the time that empowerment models can be implemented successfully. **Each model is useful at some point and with some persons.**

Social Reconstruction—Methods for Reversing Breakdown

Social reconstruction was developed as a model for reversing the effects of social breakdown, or as "a benign cycle of increasing competence through social inputs."[1] The underlying assumption of this model is that inputs may be made at any stage of the social breakdown syndrome to interrupt the cyclical, self-perpetuating chain of events. The outcome of such interruptions may be a temporary or permanent slowing, cessation, or reversal of the breakdown syndrome.

Social reconstruction is based on the assumption that older persons in our society are vulnerable, and a variety of approaches are required to meet their multiple needs most effectively. These approaches include societal, environmental, and psychological interventions at each stage in the breakdown cycle.

SOCIETAL INTERVENTIONS:

Productive work activity is valued in American society to the point that persons who do not engage in productive activity are devalued. Although retirement is a "normal" phase of life in which persons are freed from the responsibilities of work, the lack of employment during this period still results in a devalued status because of dominant social values. To the extent that self-worth is reflected in the opinions of others, **the self-esteem of older persons can be lowered as a result of their lack of gainful employment**. If self-worth were not viewed as being contingent on economic productivity, older persons

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would be free to cultivate and enjoy alternate avenues to self-fulfillment.

Numerous studies indicate attitudes toward older persons generally are negative, stable over time, and resistant to change. Those who hold these attitudes include providers of medical and social services, younger persons, employers, family members, and older persons themselves. As the "baby boomers" age and older persons become the predominant group in society, some changes in perceptions of aging can be anticipated. However, these positive trends do not attenuate the need to advocate actively *now* for needed changes in the perceptions of older persons in our society.

Changes in legislation and public policy have served as catalysts for societal changes to help improve the quality of life for older persons, especially those with disabilities. These changes include the development of a national "older worker policy," additional raises in the retirement age, changes in Social Security benefits, new laws to help prevent abuse of the elderly, and legislation that addresses the needs of care providers (such as a family leave bill).

Persons in the helping professions can play a vital role in influencing these needed changes through advocacy efforts on behalf of all citizens, including those who are older and disabled. In addition, service providers must examine their own attitudes and work to change negative stereotypes that limit the services provided to older disabled clients.

ENVIRONMENTAL INTERVENTIONS:

Adaptation and ability among older disabled persons can be promoted through improvements in the nature of, and access to, social services, such as by providing better and more accessible housing, transportation, and shopping services. **Many older persons can still live independently in their own homes if they have assistance with housekeeping, preparation of meals, and/or a source of transportation for needed trips to physicians' offices, hospitals, or shopping centers. The primary goal of such services should be to keep people independent; the secondary goal should be to assist them in coping following significant declines in resources and self-esteem.** (The assumption here is that the coping skills of older persons will increase when the environment is modified to help them remain independent.)

The greater the degree of breakdown, the more environmental interventions and the greater the degree of consistency in applying interventions will be required to interrupt the breakdown cycle. Empowering interventions cannot be optimally effective unless they are pervasive, constant, and the result of a commitment on behalf of all service providers. In this context, empowerment becomes a philosophy, so that *everything* that happens to an older disabled person is filtered through a lens of empowering concepts, issues, ideas, attitudes, and strategies. Of course, this is more difficult to accomplish in a community as opposed to an institutional setting.

Organizations and environments may be arranged along a continuum, with one end promoting and encouraging empowerment and the other end contributing to a lack of empowerment. A written philosophy of empowerment is a good first step in any setting; however, it must be followed by **staff training combined with the active involvement of older disabled clients. Persons who are involved actively in planning and controlling their daily living circumstances will be empowered with the self-confidence, motivation, and ability to believe they *can* control their own lives**. Therefore, one way to empower older clients in any setting is to provide a means of involvement that promotes a sense of ownership and control. Advisory boards and resident councils are examples of such strategies, as are family support groups and advisory boards that include family members.

PSYCHOLOGICAL INTERVENTIONS:

Several psychological reactions are inherent in social breakdown: learned helplessness, change in locus of control from internal to external, depression, and discouragement. Individually and collectively, these reactions lead to a **reduced sense of self-efficacy and a loss of personal power**.

Learned Helplessness and Change in Locus of Control

Learned helplessness and changes in perception of control from internal to external are psychological reactions to circumstances in which personal control is ineffective. These phenomena are accompanied by a reduced sense of self-esteem and well-being. To overcome these reactions, **some means of providing the experience of being in control will be required**. Of course, this is easier said than done, and it is more difficult in some circumstances than others.

Older persons who have learned to be helpless need assistance in sorting out the consequences, both good and bad, that can be attributed to their behavior, the behavior of others, or the general circumstances in which they find themselves.[19] It is necessary to sort out consequences in relation to time, noting that what happened in the past need not necessarily occur again in the future, events that occur in one context need not necessarily generalize into others. **Environmental modifications may be required to structure events by which older persons experience successful outcomes as a result of their own actions.**

Cognitive and perceptual distortions of the significance of events, even in the absence of objective facts, can lead to learned helplessness. As a result, **rehabilitation providers must assist older persons and their families in setting realistic, achievable goals to help overcome feelings of learned helplessness and lack of control. Accurate appraisals of personal and familial strengths and limitations are necessary.** Some balance is required between structuring the environment to **permit easy successes**, which may be discounted, and providing enough challenge to foster a sense of accomplishment that will be internalized and generalized.

Depression and Discouragement

Depression has been identified as the most common mental health concern among older persons. It can be an overwhelming emotion that immobilizes a person and leads to a self-perpetuating cycle of withdrawal, isolation, and declining physical and mental health. In extreme cases, electroconvulsive therapy (ECT) may be the treatment of choice for older persons with depression that may be life threatening.

Most older persons benefit from a combination of cognitive and behavioral techniques. **Successful treatment involves obtaining baseline behavioral data, examining self-talk and cognitions, and developing a series of interventions to change both the behavior and cognitions in an attempt to alleviate the depressive episode.**

For cognitive-behavioral techniques to work, the older person must be motivated to participate in the treatment process. Encouragement is a technique that helps provide such motivation and helps others focus on their strengths while developing a **positive sense of self-worth**. Steps in the encouragement process outlined by Sweeney[20] include:

- **Focusing on *what* one is doing rather than *how* one is doing**
- **Focusing on the present more than the past or the future**
- **Concentrating on the person and not his or her actions**
- **Emphasizing effort rather than outcome**
- **Fostering intrinsic motivation**, such as a sense of personal satisfaction, rather than extrinsic, such as praise from others for a job well done
- **Concentrating on what is being learned rather than on what is not being learned**

- **Concentrating on what is being done correctly rather than what is not being done correctly**

Self-Efficacy and Empowerment

The encouragement of self-efficacy through empowerment is a vital strategy for interrupting and reversing the breakdown cycle. Helping older clients experience a **sense of control in the management of their lives and promoting a view of them as capable and self-determined fosters a sense of empowerment.** This may require significant modifications in the environment as well as in individual perceptions of responsibility and choice.

When certain groups are considered, it is possible to find both research and demonstration projects that target perceived loss or lack of power. **Group strategies include the need for consciousness raising and awareness, the promotion of a desire for change, education to develop leadership and assure the continuation of empowering strategies, advocacy for changes in laws and regulations that limit disempowered groups, and the selection of appropriate target groups and methods for affecting positive outcomes with those groups.** The process for gaining power is difficult, often lengthy, and leaves the disempowered group in a position of demanding rights and recognition.

In contrast to group methods, there are no well-defined, universal stages for the empowerment of individuals. The social breakdown and social reconstruction models mentioned previously provide a context for empowerment of older disabled clients that considers the realities of later life while working to **build personal strengths through individualized—as well as group—strategies. Empowerment requires patience, an ability to mobilize others, and a focus on assuring that those who need to experience a sense of self-efficacy are able to do so.** At some point after the empowerment process begins, external inputs are likely to give way to self-encouragement and self-empowerment. Such changes are necessary if older persons are to be active participants in their own rehabilitation. As passive recipients of services, even the best efforts at rehabilitation will be ineffective. On the other hand, **self-efficacy is self perpetuating.** Once it has been lost in reaction to late-life challenges, self-efficacy may be regained and retained through strategies that enhance personal power.[21]

Summary

The unique circumstances of later life place older persons at risk for developing a variety of physical as well as psychosocial problems. **Older persons with disabilities comprise the majority of the older population. Both vocational and independent living services may be required if these persons are to continue living independently as long as possible.**

Many older disabled persons experience a social breakdown syndrome leading to low self-esteem, an impaired sense of self-efficacy, and an external locus of control, all of which result in a lack of perceived personal power and inability to take action on one's own behalf. **If rehabilitation efforts are to be successful, it is imperative that rehabilitationists be prepared to implement strategies that foster both external and internal empowerment of older disabled clients.** These strategies require **consistent effort, patience, and the ability to be satisfied with small gains that, when repeated, will lead to greater perceptions of self-efficacy and the increasing ability for older disabled persons to seek and obtain the services they require to maintain a sense of satisfaction and independence in their later years.**

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Questions Based on this Lesson

41. Which of the following is not cited as an adverse effect on the rehabilitation process of older persons?

    A. The client's perception of devaluation and low sense of self-esteem and self-worth

    B. Many elderly clients' eagerness to participate in self-improvement programs

    C. The opinion that elderly clients are poor candidates for vocational rehabilitation

    D. Negative stereotypes directed at elderly persons

42. The social breakdown syndrome:

    A. Is a positive, self-reinforcing effect of aging that increases physical and psychological functioning

    B. Never affects those who have been independent in earlier life

    C. Is characterized by four stages and can ultimately result in depression, hopelessness, and learned helplessness

    D. Refers to the gradual decline of the community in which the elderly person lives

43. Consider the following statement:

    "As people get older, they participate in a mutual withdrawal from the rest of society."

    Which theory of aging is being expressed here?

    A. Continuity theory

    B. Disengagement theory

    C. Engagement theory

    D. Activity theory

44. Which of the following statements regarding models of helping is true?

    A. In the medical model, persons are viewed as responsible for the solutions to their problems, but not for their condition

    B. In the moral model, persons are viewed as responsible for the solutions to their problems, but not for their condition

    C. In the compensatory model, persons are viewed as responsible for both their condition and the solution to their problems

    D. In the enlightenment model, persons are viewed as responsible for their condition but not for the solution to their problems

Directions in Rehabilitation Counseling

VOLUME 4 • LESSON 12

Work Hardening: A Dynamic Process

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Editor's Note

Based on the "work cure" movement of the first World War, work hardening programs are the most recent incarnation of work therapy in the field of rehabilitation. The goal of these programs is to improve clients' physical abilities to permit a return to work after an illness, accident, or injury. Although the therapy is oriented primarily toward physical rehabilitation, additional types of therapy are often used: occupational therapy, vocational evaluation and rehabilitation, and psychotherapy. The authors stress the importance of continuing the interdisciplinary therapy in work-like settings.

An often-overlooked, crucial aspect of work hardening focuses on the client's transition from the "patient personality" to the "worker personality." It is suggested that this transition is easier when the rehabilitation team considers that the individual is a worker first, and a patient second.

Finally, three models of work hardening programs are described: the sports medicine/exercise model, the work activity model, and the interdisciplinary model. An outline of the therapeutic process is provided, and the role of the referring rehabilitation counselor is discussed.

Introduction

Work hardening is generally described as **the rehabilitation of an injured worker with the goal of improving a person's physical abilities so that he or she is capable of returning to work**. Work hardening may also be known as work conditioning, work therapy, transition work programs or other similar names. As a service, work hardening is one of the fastest growing fields of health care today, being **driven directly by the spiraling cost of workers' compensation and new federal legislation such as the Americans with Disabilities Act** (ADA).[1]

Work hardening programs are rooted in the early work of occupational therapists and the "**work cure**" **movement of the first World War**. Craft activities were originally adopted to help select appropriate training for patients. The more scientifically based medical community influenced occupational therapists to embrace "work therapy" as it is regarded in the private sector.

Occupational therapists established work evaluation programs using competitive work activities and specific work samples. Reliability of instruments was improved, and formalized reports matched evaluated skills to job skills from the *Dictionary of Occupational Titles*.[2]

The Vocational Rehabilitation Act of 1920 and its amendments in 1943 and 1954 increased funding for vocational programs and included those persons in need of physical restoration among its population. Matheson and colleagues[3] note that these expanded opportunities brought about the occupational and curative workshops of the 1940s and 1950s. **These workshops used graded activities to improve function and used the patient's job demands as guidelines.**

Early program models for formal work hardening and evaluation began in medical physical rehabilitation centers in order to develop a stronger professional identity.[4] These programs documented by Worshell,[5] Stevens,[6] and Ayers[7] first used the now popular multidisciplinary team approach.

Work hardening models of the 1980s and 1990s continue to promote the multidisciplinary approach, but with better defined programs and goals. Indeed, the early efforts of pioneers such as Len Matheson and Keith Blankenship are reflected in many of today's programs. Expanding need has dictated the addition of new professionals such as exercise physiologists, job coaches, and engineers.

Definition

Work hardening programs are as diverse as the many different settings in which they are offered. Likewise, the programs are as complex as the kinds of injuries and types of employment that are often present in the community. **Work hardening programs often reflect the needs of a particular community or the personalities and strengths of the professionals involved in the treatment process**. Obviously, programs vary greatly from city to city and state to state. In general, however, **work hardening programs should be very individualized** and should **address the client's particular problem as it relates to returning to gainful work activities**.

Matheson[4] defines work hardening as "**an individualized work oriented treatment process involving the client in simulated or actual work tasks that are structured and graded to progressively increase tolerances, stamina, endurance, and productivity with the eventual goal of improved employability**." The Vocational Evaluation and Work Adjustment Association[8] has adopted this definition and refers to it in its *VEWAA Glossary*. The Commission on Accreditation of Rehabilitation Facilities[9] (CARF) has expanded this definition somewhat; it appears as follows in its *Standards Manual for Organizations Serving People With Disabilities*:

> Work hardening programs, which are interdisciplinary in nature, use conditioning tasks that are graded to progressively improve the biomechanical, neuromuscular, cardiovascular/metabolic, and psychosocial functioning of the person served in conjunction with real or simulated work activities. Work hardening provides a transition be-

tween acute care and return to work while addressing the issues of productivity, safety, physical tolerances and worker behaviors. Work hardening is a highly structured, goal oriented, individualized, treatment program designed to maximize the person's ability to return to work.

Although the CARF definition is somewhat longer, there are several areas in which both definitions agree. First, **the work hardening program should be highly individualized and designed to meet the needs of each client's particular situation**. Second, **simulated or actual work tasks should be involved in this process and structured and graded so that the client's tolerances, stamina, and endurance will be progressively increased to the point where he or she will be employable again**. Obviously, depending on the extent of the initial injury, each client will require different amounts of time in the work hardening programs.

Table 1 identifies the characteristics often associated with the "**worker personality**" as opposed to the traditional "**patient personality**" that develops when an injured worker remains out of the work force for an extended period of time.[10] **The ultimate goal of a work hardening program is to support the metamorphosis from the "patient personality" to the "worker personality"** in order to facilitate timely return to work.

These definitions of work hardening emphasize the **importance of work-like settings**, as well as the expectations and mind set of the worker. **Reestablishing the "worker personality" should be a critical part of the process that has often been overlooked by traditional medical models and treatment facilities**. By approaching the client as a worker and creating an environment that fosters trust and understanding, the unique needs of each injured worker can be identified and resolved effectively.

Work Hardening Models

Work hardening programs exist in a variety of configurations and settings, but in general seem to follow the

Table 1

PATIENT PERSONALITY CHARACTERISTICS VERSUS WORKER PERSONALITY CHARACTERISTICS

Patient Personality	*Worker Personality*
• All supervision is considered criticism	• Willing to accept supervision
• Not willing to meet employer time demands	• Willing to adhere to work schedule
• Coworkers looked upon suspiciously	• Willing to participate with coworkers
• Unmotivated and indifferent to achievement of goals	• Able to pay attention to detail
• Cannot focus on a specific goal other than health	• Able to set realistic goals (both short- and long-term)
• Blames all problems on outside forces	• Able to accept personal responsibility
• Becomes focused unproductively on the injury	• Able to place injury-related problems into perspective
• Becomes injury dependent—search for total cure	• Able to recognize limits
• Looking for a financial windfall to solve all problems	• Able to manage financial resources
• Becomes alcohol or drug dependent	• Able to avoid alcohol and drug dependency
• Wanders aimlessly through the day	• Able to manage personal time
• Turns life over to outside influences	• Able to manage outside influences
• Refuses to compromise or alter behavior	• Attempts to follow corrective instructions
• Ignores safety steps during services	• Demonstrates caution, but will attempt activity
• Overreacts or underreacts emotionally	• Demonstrates full range of emotion

orientation of the staff involved in the treatment process. **Programs can range in complexity from basic exercise to very comprehensive multidisciplinary programs**. It can be expected that a more complicated rehabilitation case will require a more complex program in order to meet the client's needs.

Different models to be discussed include: the **sports medicine/exercise model**, the **work activity model** and the **integrated vocational or interdisciplinary model**. For purposes of this discussion, these models progress in complexity and comprehensiveness as well as increased involvement of various disciplines.

SPORTS MEDICINE/EXERCISE MODEL:

Typically, these programs are **staffed by physical therapists** and tend to be **based in a hospital as an extension of a physical therapy department**, or operated as an **extension to acute rehabilitation service in a private clinic**. Therapists in this type of program establish **goals to increase mobility, strength, and self-confidence**. Program activities include **stretching and general body conditioning** with special attention paid to the injured area of the body. Specialized body building equipment, such as the Nautilus, Nordic Track, Mini-Gym, or Cybex, may be used in this process. Other traditional equipment (weights, treadmills, exercycles, and barbells) are also common. **Work-related activities involve materials such as bricks, concrete blocks, hand trucks, wheel barrows, and possibly crates that are lifted to predetermined shelf heights**.

A program at this level is **most useful in uncomplicated cases**, when **the main problem facing an injured worker is physical conditioning** secondary to an illness or injury. It should be noted that the highly motivated client will most likely benefit from this type of aggressive rehabilitation program.

A typical day in this type of program includes: stretching; strengthening exercises; exercises to increase tolerance and stamina using exercycles, treadmills, or aquatic exercises. In addition, these programs involve instruction in correct body mechanics, posture, anatomy, physiology, and other topics that might foster a general understanding of the injury.

Work hardening programs that use a sports medicine/exercise approach adopt the philosophy and goals of the sports trainer: to allow the injured athlete to function and to get him or her back to 100% performance as soon as possible. To accomplish these goals, **the injured athlete begins passive exercise/therapy immediately following the injury** (assuming medical feasibility) **progressing to active, resistive, exercise, and muscle restrengthening**.

WORK ACTIVITY MODEL:

Building on the sports medicine/exercise model is the work activity model. This model **includes the general conditioning and exercise approaches of the sports medicine/exercise model in addition to more in-depth work simulation activities. Work simulation activities should represent the actual jobs and/or industries indicated by the job goal for the client**. The job simulation activities can either **replicate the actual tools and materials** used by the worker in past work or simply **replicate the biomechanical movements** necessary to perform past work or job goal of the client. These work simulation activities may be built by the center's personnel or purchased through commercial work sample/work simulation manufacturers. In this model, **a variety of rehabilitation specialists may be used in addition to physical therapists, including occupational therapists, vocational specialists, rehabilitation engineers, and exercise physiologists**.

Moreover, **it may be determined** through the use of on-site (ergonomic) job analysis **that a client may not possess the ability or physical capacity to return to his or her previous occupation**. In this case, the staff

(occupational therapist, vocational evaluator) may perform **vocational testing and/or transferability of skills analysis to identify feasible occupational goals. Vocational testing also may be used to measure a person's vocational aptitude, educational skills, vocational interest, temperaments (personality variables), and cognitive abilities.**

A typical day in this type of program begins with **stretching and strengthening activities**, followed by carefully selected **work simulation activities** designed gradually to build work tolerance consistent with the job goal. Participants also are involved in **instructional programs aimed at increasing their understanding of proper body mechanics, occupational safety, and injury prevention.**

Participants in this work activity model have greater needs than those in a sports medicine/exercise program. It should be expected that clients in these programs may be involved on a 3–5 day-per week program for a longer period of time as indicated by the nature and severity of the injury. Total program length at this level depends on the severity of the injury.

INTEGRATED VOCATIONAL/INTERDISCIPLINARY MODEL:

For the more complex rehabilitation case involving complicated issues and/or extended length of disability, an **integrated vocational/interdisciplinary model** as described by CARF is the most appropriate. This model **includes all of the approaches to service-delivery of the previous models and may also incorporate psychological services, job development/placement services, dietary-nutritional counseling, substance abuse counseling and industrial engineering/rehabilitation engineering.** (Please see Table 2 for a sample daily schedule.)

To receive CARF accreditation, a program must adhere to the following standards:

Table 2
SAMPLE DAILY SCHEDULE FOR INTERDISCIPLINARY/VOCATIONAL MODEL

8:30 AM–9:15 AM	Warm-up; walk
9:15–9:30	Break
9:30–10:00	Everyday strength exercises
10:00–10:45	Stretch
10:45–11:15	Individual/group counseling
11:15–12:00 PM	Educational session
12:00–1:00	Lunch
1:00–2:00	Work hardening
2:00–2:15	Break
2:15–3:45	Work hardening
3:45–4:15	Relaxation techniques
4:15–4:30	Clean-up

The interdisciplinary team should be made up of the following professionals: Occupational Therapist, Physical Therapist, Psychologist, Vocational Specialist. Based upon the needs of the individual, the following services should be made available: Alcohol and drug counseling, dietary services, exercise physiology, industrial/rehabilitation engineering, orthotics and prosthetics, academic remediation, and social services.[9]

This model should be comprehensive enough to meet the total needs of the injured worker by addressing the issues preventing the emergence of the worker personality, and **flexible enough to address the specific needs of each individual who enters the program.**

Process

To address specific needs, realistic attainable vocational goals must be determined for each client prior to the implementation of a work hardening program. The process begins with a thorough review of the medical record, determination of the clients' current activity level, and work history review.

Physical testing begins with the determination of physical attributes; i.e., height, weight, body fat compo-

sition, cardiovascular fitness, and range of motion. **Performance testing** should be completed to measure the client's ability to meet the physical demands of work as defined by the United States Department of Labor. These variables include lifting, carrying, pushing and pulling capacity, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, feeling, hearing, seeing, and speaking. Also, **endurance factors** relative to the client's sitting, standing, and walking tolerance should be assessed.

Based on findings of this initial evaluation and the results of a functional capacity evaluation, a prescriptive individualized work hardening program is developed for the client. This plan addresses the physical needs and other services required by the client to return to work consistent with the defined job goal.

Ongoing evaluation of the client's progress is necessary to monitor appropriateness of the job goal. Program modifications may be necessary if an alternative job goal is deemed necessary. This is usually accomplished by **weekly staffings**. **Staffings are held so that each member of the rehabilitation team can discuss the progress being made by the client**. Should an alternative job goal become necessary, the team has all the information necessary to implement the needed changes.

Work Hardening Program Selection

As outlined previously, work hardening programs vary greatly. The rehabilitation specialist looking for an appropriate work hardening program should have specific client goals in mind. Also, he or she should look for specific services from the program that is ultimately chosen.

QUALIFIED STAFF:

Staff members will have degrees in **occupational therapy**, **physical therapy**, **exercise physiology** or **vocational specialties**. Training in areas of anatomy, physiology, testing, exercise, occupational information, and other medical and psychological aspects of disability should be expected. **Staff members should possess professional certificates or licenses in their appropriate fields. Additional training and experience in the areas of work hardening, functional capacity evaluation, job analysis, vocational evaluation, and job modification are often beneficial**. Manufacturers of equipment for evaluation and treatment may also offer training and/or certification in the use and interpretation of their specific equipment.

TIMELY INFORMATION:

The rehabilitation specialist should **expect weekly or biweekly reports on the progress of his or her client**. This information **should include objective measurable information by which progress (or lack thereof) can be measured**. Problems or changes in program goals should be discussed on a timely basis with the specialist. This is often accomplished by including the specialist in weekly staffings.

COMPUTERIZED TESTING:

Many programs are using computer-assisted treatment or evaluation equipment. Such methods should be closely scrutinized, but they generally **can provide additional information. Consistency of efforts using the coefficient of variation (CV) as well as objective, repeatable information can be obtained**. Computers often record testing or treatment data as it is being generated, thus **reducing the possibility of errors**. Computers may also be used to **administer testing** and to produce standardized protocols.

WORK-SPECIFIC RESULTS:

Outcomes from a work hardening program should include specific information concerning a client's ability to perform competitive work activities. Job titles and codes from the *Dictionary of Occupational Titles* accompanied by appropriate physical demands are desirable.

Standards such as those employed by industrial engineers (e.g., methods time measurement [MTMs]) can provide additional information concerning a client's ability to perform work competitively and productively.

Summary

Work hardening is a multidisciplinary treatment modality with the purpose of assisting persons to achieve a level of productivity that is acceptable in the competitive labor market.[11]

The various models presented in this lesson demonstrate the **dynamic nature of work hardening**. As we face new challenges, such as those imposed by the ADA, work hardening programs will continue to be important tools in assisting employers as they seek to create safe and productive work environments.

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Questions Based on this Lesson

45. Which of the following is not a "worker personality" characteristic?

    A. Puts injury-related problems into perspective

    B. Accepts personal responsibility

    C. Refuses to be constrained by limits

    D. Accepts supervision

46. Consider the following description:

    "...consists mainly of general conditioning and exercise, and includes in-depth work simulation activities"

    Which model of work hardening is being described?

    A. Integrated vocational

    B. Work activity

    C. Sports medicine

    D. None of the above

47. Which of the following are services that foster the emergence of the worker personality?

    A. Physical accommodations made to the workplace

    B. Academic remediation

    C. Substance abuse counseling

    D. All of the above

48. Which of the following conditions should the rehabilitation specialist not expect when selecting a work hardening program for a client?

    A. Outcomes that are specific to the client's work/career goals

    B. Frequent reports on the client's progress

    C. Measurable improvement indicated in every report

    D. Evidence of staff qualifications

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